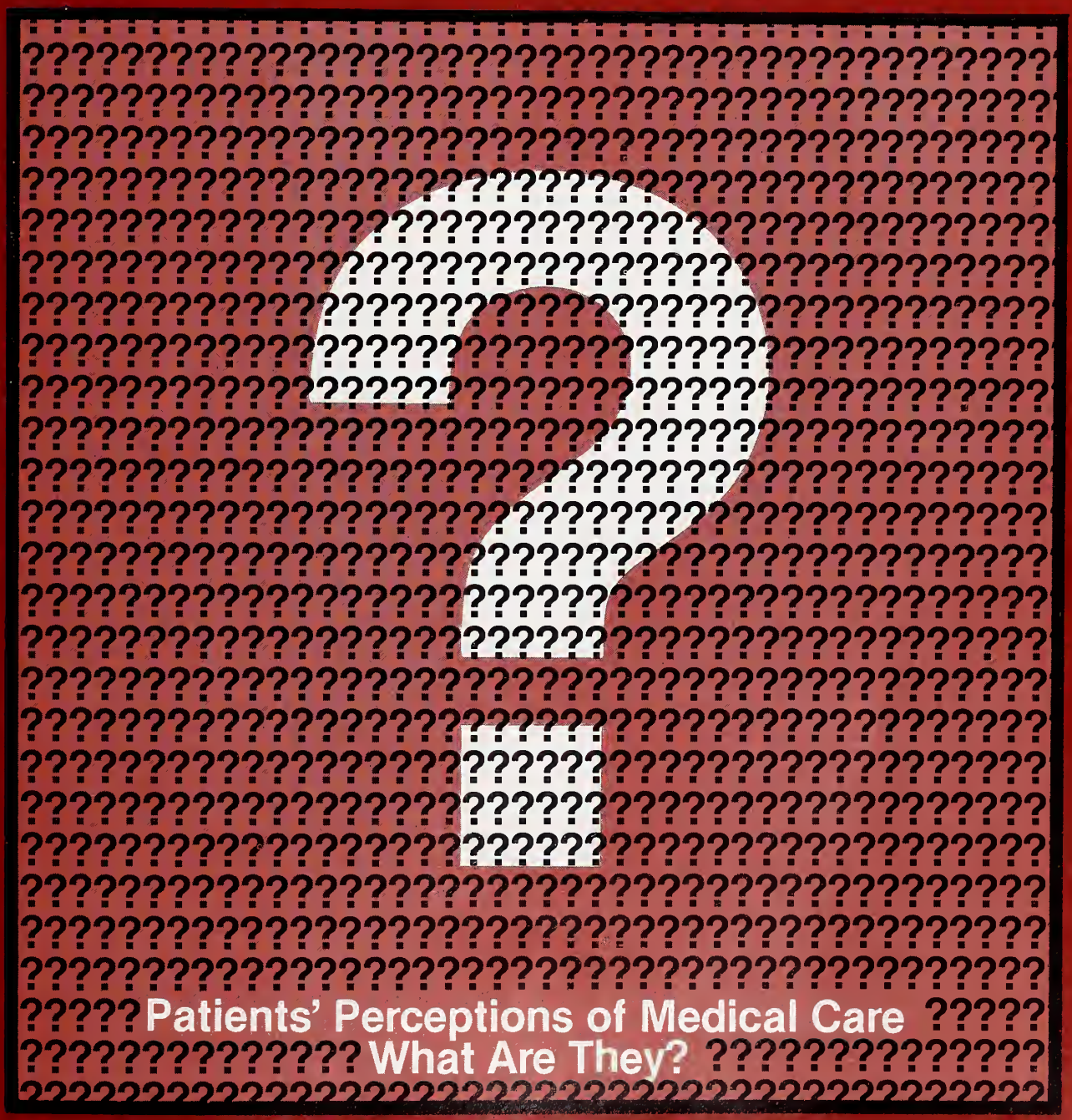
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A Brief Summary
MELFIAT® 105 UNICELLES® Ⓜ
(phendimetrazine tartrate) 105 mg Slow Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a slow release dosage form, limit to one slow release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear slow release capsule contains 105 mg phendimetrazine tartrate in bottles of 100. NDC 0063-1082-06.

CAUTION: Federal law prohibits dispensing without prescription.

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Atlanta, Georgia 30318

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Reference: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document, ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980, pp 10–15.

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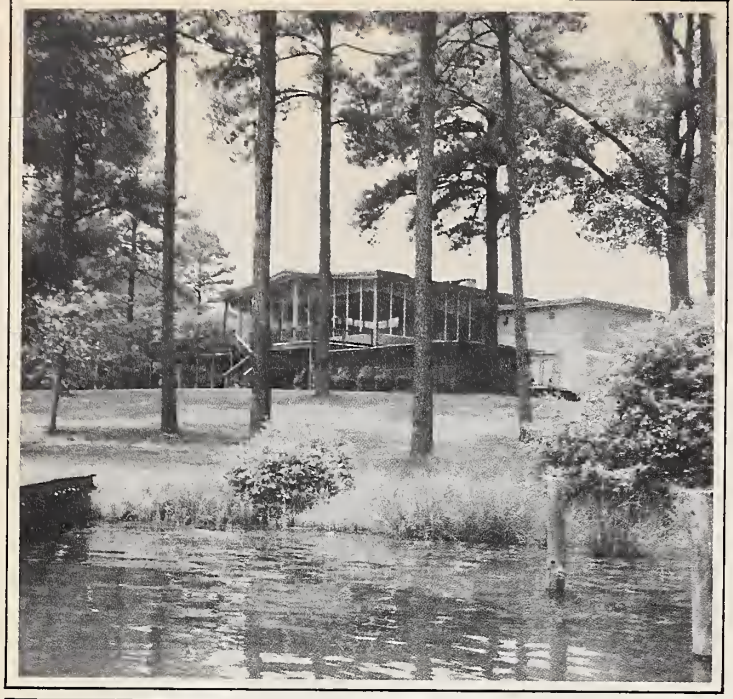
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

Artwork by Mrs. Jill Harris Brown of Atlanta.



SMOKING "CAUSED" I

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1. National Interagency Council on Smoking and Health. *The Smoking Digest* Progress Report on a Nation Kicking the Habit. 1977.

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Before prescribing, please consult full product information, a brief summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: Hypersensitivity; use with other xanthines.

Warnings: Status asthmaticus is a medical emergency. Excessive doses may be expected to be toxic.

Usage in Pregnancy: Safe use in pregnancy has not been established; do not use in pregnant women unless the potential benefits outweigh the possible hazards.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, acute myocardial injury, congestive heart failure, or peptic ulcer. Chronic high dosage is usually associated with gastrointestinal irritation.

Adverse Reactions:

Gastrointestinal—irritation, nausea, vomiting, epigastric pain, headache, hematemesis, diarrhea.

Central Nervous System—stimulation, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.

Cardiovascular—palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.

Respiratory—tachypnea, respiratory arrest.

Renal—albuminuria, increased excretion of renal tubule and red blood cells.

Others—fever, dehydration.

Overdosage:

Symptoms—In infants and small children: agitation, headache, hyperreflexia, fasciculations, and clonic and tonic convulsions. In adults: nervousness, nausea, vomiting, tachycardia, and extrasystoles.

Therapy—No specific treatment. Discontinue drug immediately. Provide supportive treatment as indicated. Ipecac syrup for oral ingestion. Avoid sympathomimetics. Sedatives such as short-acting barbiturates help control CNS stimulation. Restore the acid-base balance with lactate or bicarbonate.

Drug Interactions: Toxic synergism with sympathomimetic bronchodilators may occur.

Dosage and Administration:

Usual Adult Dosage—15 mg/kg every 6 hours, up to four times a day. Titrate the dosage individually.

How Supplied:

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NDC 0037-0521-85, box of 100 unit-dose individually film-sealed tablets.

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21-22—*Atlanta:* **Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713

30-Feb. 3—*Cancun, Mexico:* **5th Annual Scottish Rite Pediatric Postgraduate Course — Pediatrics in Review.** Category 1 credit. Contact Judson Hawk, Jr., MD, Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

FEBRUARY—1983

5-13—*Limone, Italy:* **7th Annual Conference on Pain—Chronic Pain: An International Epidemic.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-25—*Park City, Utah:* **Urology in the Wasatch Mts.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-26—*Augusta:* **18th Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-March 5—*Breckenridge, CO:* **8th Annual Snow Job in GYN/OB.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

MARCH—1983

1-4—*Durango, CO:* **Sixth Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

9-11—*Augusta:* **Electrocardiography and Cardiac Therapy.** Category 1 credit. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-25—*Atlanta:* **Practical Use of Antibiotics: Update for the 1980s.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27—*Augusta:* **Spring Meeting, Georgia Chapter, American College of Surgeons.** Category 1 credit. Contact LaMar McGinnis, MD, 365 Winn Way, Ste. 201, Decatur 30030. PH:404/292-2700.

27-29—*Atlanta:* **MKSAP VI Part II—ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

28-30—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

28-30—*Augusta:* **Genetics for the Practitioner.** Category 1 credit. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

APRIL—1983

6-8—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

6-8—*Atlanta:* **Perspectives in Parenteral/Enteral Nutrition.** Category 1 credit. Contact Lynn Smith, RN, Program Chairman, Metabolic Support Svc., Ga. Baptist Med. Ctr., 300 Blvd., NE, Atlanta 30312. PH:404/563-4496.

7-8—*Atlanta:* **Otolaryngology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Lake Lanier Islands:* **Update of Hepatobiliary Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

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8—*Atlanta:* **Neurology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

10-14—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

11-13—*Atlanta:* **Pediatric Neurology: Currents and Controversies.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

15-16—*Atlanta:* **Atlanta Eye Congress.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

17-18—*Atlanta:* **Internal Medicine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24—*Atlanta:* **Postgraduate Course—Pancreas, Liver, and Biliary Tract.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

25-27—*Atlanta:* **Scientific Program of the Southeastern Surgical Congress.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

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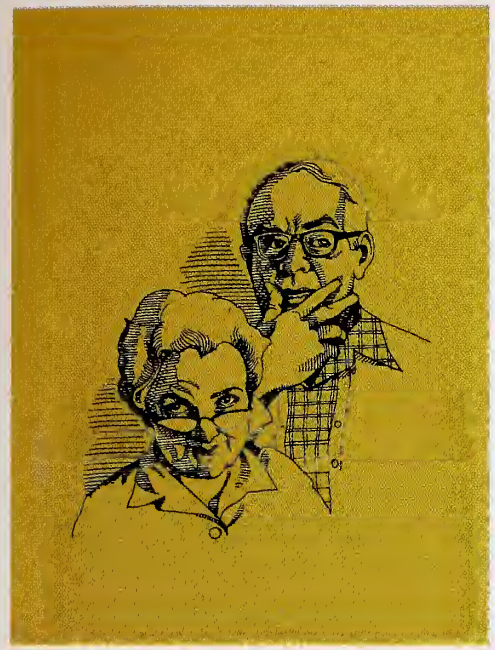


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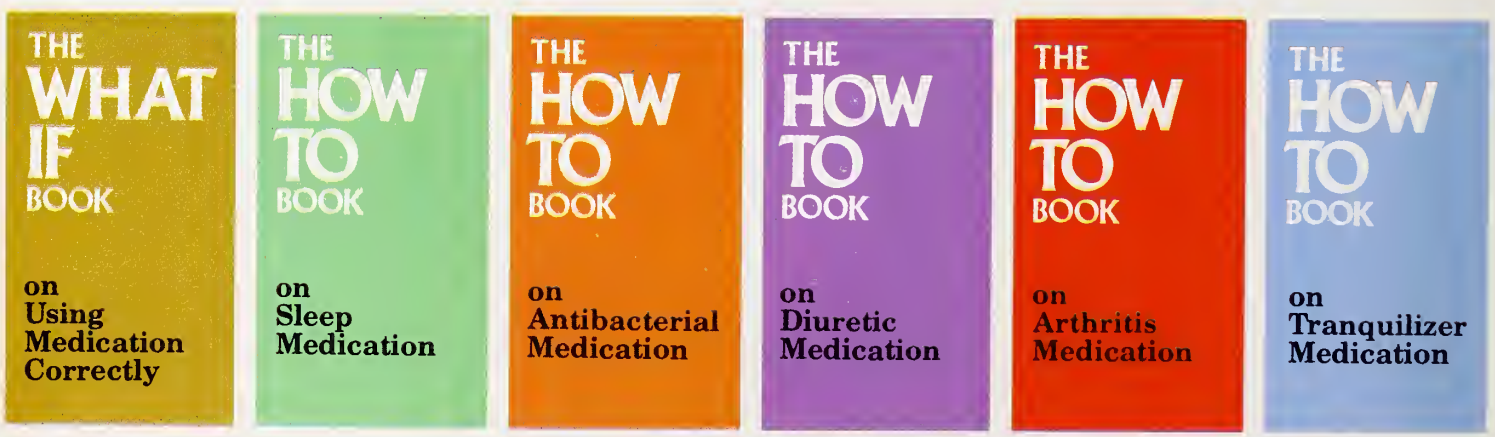
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The Public Speaks — Part I

CHARLES W. McDOWELL, JR., M.D., *Decatur,* and KEN WILLIAMS, *Atlanta**

How does the public view physicians? Is the public satisfied with the care we provide? What are the main problems facing medicine today, as viewed by the public? And who deserves the responsibility for rising health care costs?

These and more than a hundred other questions were answered in a recent public opinion survey conducted in Georgia. The polling firm was a New York-based research organization — Kane, Parsons and Associates, Inc.

The survey, the most extensive ever conducted in Georgia on health care topics, was commissioned by the MAG Board of Directors at the request of the Public Relations Committee.

The public opinion questionnaire was developed in consultation with the American Medical Association (AMA). The AMA has commissioned a similar survey on a national basis, but Georgia is one of only three state medical associations participating in an in-depth way in the 1982 AMA survey research program. The other states are Oklahoma and Iowa.

During the week of August 9-16, 1982, a total of 406 Georgians, representing rural/urban, black/white, rich/poor, young/old segments of the public, were questioned in a 12-16 minute interview over the telephone.

In this issue of the *Journal* and in subsequent issues, we shall let you know what "John Q. Public" said about physicians specifically and health care in this country generally.

Many of us believe that we know what our patients think about us. After all, we say, collectively we see thousands of them daily. But this recent survey indicates that some of our assumptions are not only naively misleading but also realistically wrong.

Allow me to share with you some of the questions asked of John Q. and you fill in the blanks.

Georgia was one of three states participating in an in-depth way in the 1982 AMA survey research program. This article introduces some of the survey's salient* and surprising *results.

After taking the quiz, check your answers by turning to page We are paraphrasing some of the questions because of space limitations.

The Questions

1. Now, thinking about everything that has to do with health care, medicine, and doctors, what do you feel is the main problem facing health care and medicine in the United States today?

2. Let's think about the way our society spends money on various problems. Do you think we as a society are spending too much money, not enough money, or about the right amount on . . . (several topics were listed) How about health care? Do we spend too much, too little, or about the right amount?

3. Do you think we have enough doctors, too many, or too few?

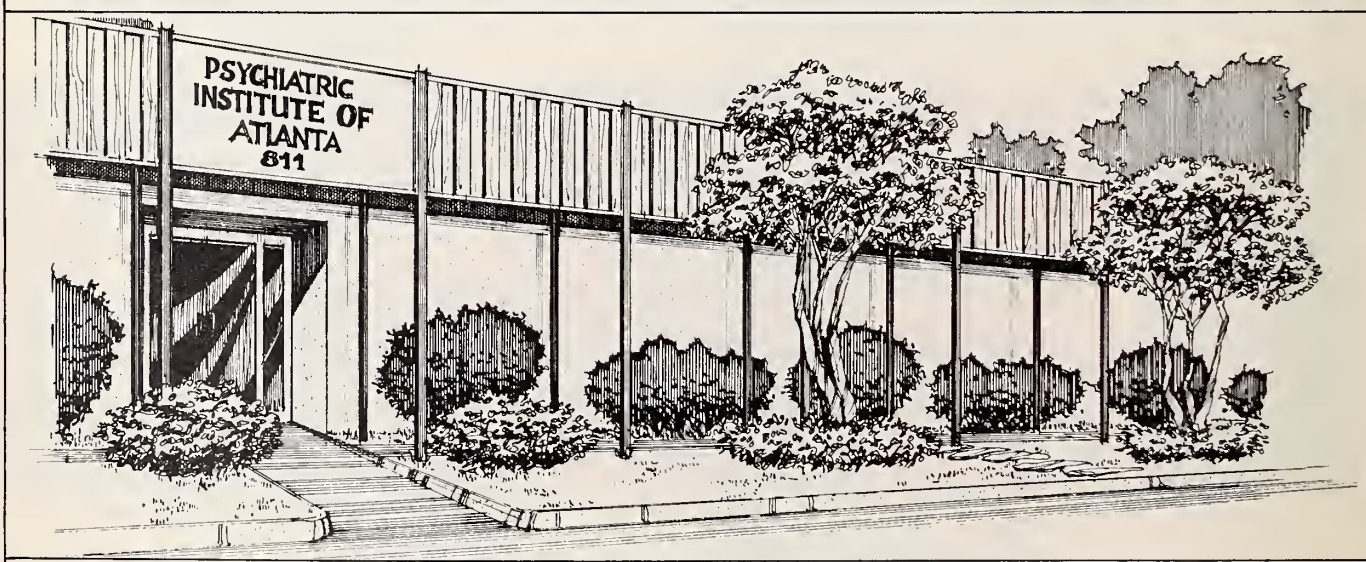
4. Are you satisfied with your most recent visit to a physician's office.

* Dr. McDowell practices ophthalmology and is Chairman of MAG's Public Relations Committee; Mr. Williams is Director of Public and Professional Relations for the MAG. Send reprint requests to Mr. Williams at 938 Peachtree St., NE, Atlanta, GA 30309.

5. Are you satisfied with the amount of time you had to wait in the physician's office?
6. How did you choose your personal physician, i.e., recommendation of friends, doctor's fees, doctor's qualification, etc.?
7. How important are the fees your doctor charges in deciding whether to remain with your physician? Very important? Fairly important? Not very important? Not at all important?
8. Do you think doctors take a genuine interest in their patients?
9. Do you think doctors act like they are better than other people?
10. Do you think poor people are able to get needed medical care?
11. Do you think people are beginning to lose faith in doctors?
12. Do you think doctors usually explain things well to their patients?
13. Are you confident that you have enough money or health insurance to pay for the usual medical costs that your family requires?
14. Are you confident that you have enough money or health insurance to pay for a major illness?
15. Which person or what groups deserve the responsibility for the rising costs of medical care?
16. Is it ethical for doctors to advertise?
17. Do you believe good doctors will advertise?
18. Do you think people who sue physicians are usually justified in bringing suit?
19. Do you believe doctors' fees are usually reasonable?
20. Rather than being treated by your regular doctor, would you object to being treated by a group of doctors, like a clinic?

John Q.'s answers may surprise you, delight you, disappoint you, and they may also confirm how you think he views physicians and health and medical issues. Take a minute to answer the quiz. You can compare your knowledge by checking your answers to John Q.'s which appear on page 63.

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A variety of experts shared their insights and knowledge on issues related to medical care in our complex society.

Another "first" for the Association . . .

MAG Leadership Conference Rated a Huge Success!

STEPHEN DAVIS and JOYCE BUTLER, *Atlanta**

THE MAG'S FIRST Leadership Conference was by all accounts a real triumph.

Held at Callaway Gardens during November 12-14, 1982, the Conference drew 146 physicians and society staff for a weekend of stimulating presentations by a variety of speakers. Their topics were among the most important issues facing physicians: hospital/medical staff relations, professional liability, peer review, credentialing and quality assurance. Experts from all over the nation brought their knowledge of these subjects to Callaway, and their presentations were enthusiastically received.

The Leadership Conference began on Friday morning with MAG President Charles D. Hollis, Jr., explaining the reasons why the Association had arranged the Conference. One of the most important was the need for Georgia physicians to stay informed of and respond effectively to the pressing issues related to modern medical care. William R. Fifer, M.D., of Minneapolis, spoke next on "Credentialing and Quality Assurance." Dr. Fifer has served nationally as a consultant on this subject. He also led a program on "Medical-Legal Pressures for Accountability: Crisis and Challenge in the '80s" for the medical staff of Cobb General Hospital. Dr. Fifer emphasized the need for the medical staff, administration, and hospital authority to implement an effective quality assurance program. Existing mechanisms may be ineffective, because they are not data based, he stressed. He described approaches for data based hospital-wide systems of selecting medical staff, reviewing and certifying its competence, and assuming responsibility for all aspects of quality care.

Kent Masterson Brown, J.D., of Lexington, Kentucky, addressed the legal responsibilities and liabilities of the medical staff as they relate to each other within the facility and as a unit to "outside" agencies, such as the Federal Trade Commission in antitrust action. He also reported that more and more hospital medical staffs are finding it advantageous to use their own attorneys to help resolve differences between the administration and the hospital medical staff. Then Richard F. Corlin, M.D., of Santa Monica, California, spoke on "Changing Trends in the Medical Care Environment." "Any state that would consecutively elect first Ronald Reagan as governor and then Jerry Brown obviously has a severe identity crisis" he quipped, but his point was that current socioeconomic shifts are rapidly altering traditional ideas of medical care. To deal with these, Dr. Corlin stressed the need for ongoing analysis of the economy, demographic changes, manpower, technology, and government regulation. Long-range planning with flexibility to accommodate new data is equally important. Read a shortened version of his address elsewhere in this issue of the *Journal*.

In the afternoon, workshops led by the morning's three speakers allowed for a recapping of major issues. Then followed the organizational meeting of MAG's proposed Hospital Medical Staff Section. Officers were elected and bylaws were approved. If implemented by the MAG House of Delegates, the Section will provide for

* Mr. Davis is MAG's Director of Education, and Mrs. Butler is an Assistant Executive Director of the MAG. Send reprint requests to Mr. Davis at 938 Peachtree St., NE, Atlanta, GA 30309.

direct participation in the House by physicians representing hospital medical staffs.

Jack A. Raines, M.D., Chairman of the MAG Board of Directors, keynoted the Conference on Friday afternoon. In order for "MAG to get things done for organized medicine," he urged that Georgia physicians must get involved in MAG. This means exchanging viewpoints in committee, then supporting the committee in its action. Dr. Raines punctuated his address with some lively music and added that a key element of MAG involvement was to call STAFF, "even if you have to ring twice." His remarks appear in another article in this issue.

If the Hospital Medical Staff Section is implemented by the MAG House of Delegates, the Section will provide for direct participation in the House by physicians representing hospital medical staffs.

The day's activities closed with another opportunity for participants to swap opinions — this time in a "social hour" at the cocktail bar, sponsored by MAG Mutual Insurance Company.

The next day also offered a blend of information, interaction, and relaxation. On Saturday morning, Dr. Corlin gave an overview of hospital/medical staff relations. Ronald E. Henderson, M.D., President of the Medical Association of the State of Alabama, next related his experiences with the Birmingham medicine-business coalition. Such coalitions were necessary, he said, in order for physicians to interact effectively with the four other forces involved in today's medical care: business and industry, the federal government, hospitals and hospital corporations, and third party reimbursers. Ending the morning's program was Wyndham B. Blanton, Jr., M.D., of Richmond, Virginia. A main point of his remarks on peer review included a detailed description of the differences between PSRO and the Utilization and Quality Control Peer Review Organizations (UQCPRO), required by the Tax Equity and Fiscal Responsibility Act of 1982. These UQCPROs will provide utilization and quality control peer review for Medicare.

But it was almost SRO* forty miles away at Jordan-Hare Stadium in Auburn, where the Georgia Bulldogs battled the Tigers for the SEC Championship. MAG did the next best thing to providing tickets — it arranged a bus to the stadium for Conference attendees, complete with box lunches and liquid refreshment. For those without tickets, MAG Mutual offered its hospitality suite. There refreshments were offered and the radio blared with Larry Munson's inimitable play-by-play announcing. Other Conference participants availed themselves of Callaway Gardens' tennis courts and golf courses. That evening, an elaborate reception allowed for more camaraderie.

Sunday morning's program began with A. Derrill Crowe, M.D., President of the Mutual Assurance Society of Alabama, who related his state's experience in establishing a physician-owned professional liability insurance company. Following was U.S. Representative Ed Jenkins of Georgia's Ninth Congressional District. He explained the status of legislation affecting the Federal Trade Commission, as well as the FTC's complicated procedures for action.

Concluding the Conference, James P. Low of Washington, D.C., impressed upon attendees the need for an active and broad basis of physician support to enable the MAG to work effectively. He also suggested guidelines for the Association's leadership and staff. Each has clearly defined areas of responsibility, he noted, and along with a concerned membership, the Association can make great strides in the future.

The success of the Leadership Conference is best judged from the participants' opinions. Half of the attendees returned written evaluations, and of these 98% rated the weekend as "excellent" (the rest replied "good"). But it is their written comments which are most informative.

Here's a sampling:

— "Outstanding Conference! Thought-provoking — anxiety producing!"
— "This is the best meeting MAG has ever put on as far as the information we received."
— "My personal congratulations/gratitude and appreciation to everyone involved in planning and operation."
— "This was a most worthwhile, educating, and informative conference."
— "Suggest you have another when and as often as possible."
— "Excellent meeting — I'm so glad I came!"

On the strength of these glowing comments, as well as others (one participant suggested scheduling another meeting during the Georgia-Auburn game!), the Medical Association of Georgia is sure to conduct another Leadership Conference sometime in the future. The consensus among our recent attendees as to future date seemed to be: whenever there are topics and issues again arising, demanding the attention of Georgia physicians and their Medical Association.

* Standing Room Only.

The author invites you to address yourself to the spirit of MAG and what it means to physicians individually and collectively.

Getting Things Done for the MAG

JACK A. RAINES, M.D., ***Columbus****

In order to get things done for MAG, the first thing you must do is call STAFF. The fact is that getting things done for MAG is a matter of spirit more than technique. What matters is our joy, enthusiasm, a sense of identity, fellowship, a shared heritage for a major portion of our lives, and above all, an abiding sense of gratitude that we are privileged to be a physician in this life.

No, it is not really necessary to say these things. It is certainly not necessary to trumpet them symbolically with musical fanfare or even to announce them from a podium. *It is necessary* that you permit yourself to be aware of these feelings, whatever your personality, whatever your level of technical competence, however thick your armor of cynicism, leave room for the heroic epic. Look past the tedium, the repetitious effort, the perennial problems, address yourself to the *spirit of MAG* and not just to the harsh realities.

The most gifted artist at the peak of creativity captures only a spark of that which his soul perceives. MAG was not created by Michelangelo. At times I might be persuaded that Salvador Dali was a founding father. Our predecessors constructed a multipurpose vehicle. MAG is a scientific organization, a political force, a fraternal organization, a group conscience, a torch bearer of our collective ideals. Like the camel, MAG is a creature of function, not an esthetic adornment. You may be too old to cry when you watch Lassie on TV but there should be tears in your heart. Old Glory should still remind you of Pearl Harbor, Iwo Jima, Colin Kelly, and Flanders Field. Oh yes, Lassie is only fiction and Old Glory has waved over many a sad atrocity. If you are to get things done for MAG, you must feel the meaning of the symbol, however far we miss the mark at any point along the unending way. Call STAFF — have spirit!

Each of us is different. We are not better or worse, more effective or less effective — we are simply and wonderfully different! You do not attempt to open the back door with the front door key nor do you eat soup with a fork. When design dictates the function without explanation, a pinnacle of achievement has been reached. It is difficult to imagine a man so primitive that he would hold the blade and chop with the handle of the ax. Even a chimpanzee soon distinguishes between the blade and the handle of a knife.

Getting things done for MAG requires an exquisite sensitivity to this quality of faith in those colleagues who are less involved than yourselves.

Examine yourself. What are you designed to accomplish? Let me rephrase that question, what functions for MAG does your design permit? Very few are so gifted that they can function effectively in areas for which they are not designed. To get things done for MAG, do not allow yourself to be euchred into a task for which you are not designed. Conversely, search diligently through your storehouse of memories for those occasions when you, in your own judgement, have been pleased with your efforts. Analyze those situations. If you can identify the set, circumstances, or variables where you have succeeded in the past, then look for similar opportunities within MAG. Do not hesitate to try new roles. You may discover an unexpected talent.

Before someone accuses me of plagiarism, it should be obvious to all that these comments were

* Dr. Raines practices psychiatry and is Chairman of the MAG Board of Directors. This address was given at the MAG Leadership Conference held in Callaway Gardens in November, 1982. Send reprint requests to him at 3228 Cody Rd., Ste. 106, Columbus, GA 31906.

recorded at least as early as the New Testament. As with the widow's mite, the parable of the talents, and the feeding of the multitude, share what you have, and it will be more than sufficient for the task at hand. Without reference to the religious significance of the Bible, there is one additional analogy that must be stated. We are told that Jesus said, "Inasmuch as you have done it unto the least of these my brethren, you have done it also unto me."

Thomas Jefferson tells us that a majority of one must be given the same support and adherence that would be commanded by a unanimous vote.

If you identify yourself with MAG, MAG is aided and supported by all of your endeavors. When on occasion, a patient or a member of the community expresses praise or approval of my actions, it is then my opportunity to broaden the cloak of goodwill. Love me, love my dog. I am MAG, I am AMA, I am Muscogee County Medical Society, I am a physician. If you, friend or patient, are kind enough to credit me with skill, compassion, ideals, or integrity, then hear me when I say that "organized medicine" is composed of that same degree of skill, compassion, ideals, and integrity. Organized medicine is meritorious to the extent that each single member, each component part deserves merit, no more no less. The opportunity and the obligation are constantly before us every waking moment without cessation.

Let me relate the opposite. A member of the teaching staff in a large Georgia hospital recently informed a group of students during rounds that any physician involved in politics was not a very good doctor. One of his students promptly responded, stating that his father was very active in the Medical Association and to that extent in medical politics. Furthermore, the student made it plain that his father was a fine gentleman and an excellent physician. The young man's father is a member of the MAG Board of Directors, and I would concur in the view held by his son. The attitude of the attending man is the antithesis of all that we hope to accomplish on behalf of MAG. If your colleagues respect you, in any or all of your aspects, you, in turn, can resolve any contradictions. He or she may take a dim view of MAG. They may take no view at all. Those colleagues must now ponder over the question of how it is that you a person, a physician, whom he or she admires and respects are devoted to the principles of MAG. The same applies to the community at large — neighbors, legislators, a member of the press, or whomever. You are MAG, you are organized medicine, you are the means to accomplish the goals of organized medicine. Examine your design. What functions for MAG are suited to your design? Call STAFF, have spirit, be a good instrument.

There is one more thing. To get things done for MAG you must compromise. Horrors! That repugnant word! All of this emphasis upon principle and now you are told you must compromise? A contradiction? If you wish to be remembered historically, never compromise. The Battle of Thermopylae, the Song of Roland, Custer's last stand, Casey Jones, the wreck of the old 97, let us not forget John Henry. Watch out! All of these people had replacements. Other armies took up the gauntlet after Thermopylae and Custer's last stand. Other men filled the shoes of Casey Jones and John Henry. The house of medicine can ill afford a damn-the-torpedoes, full-speed-ahead attitude. Who would replace us? The great manipulator said, "you have to go along to get along." We rightly rebel at the crass connotations inherent in this statement.

There is another concept of compromise which is not odious. It is meet and proper. It is a noble concept. Thomas Jefferson tells us that a majority of one must be given the same support and adherence that would be commanded by a unanimous vote. He further states that a failure to adhere to this concept leads to anarchy. The failure of our government to be more effective in addressing the needs of the nation stems directly from a national failure to heed the sage comments of Jefferson.

Can you as a leader in MAG set the example for your colleagues by energetically supporting the majority opinion or pursuing an effort that differs from your preferred approach?

The same is true of the MAG. A determined, conscientious, concerned individual labors long and hard to persuade MAG or a component society to move in one direction or another, to take this action or that action. When the votes are counted, MAG does something more than or less than expected. Even worse, MAG does "nothing." How many of us now support the action or inaction of the majority with the same intensity which surrounded our initial position? There may be greater sacrifices, but this task is painful to an extraordinary degree.

Listen to county society members at a meeting, listen to the delegates at the Annual Session. A consensus on the need often exists side by side with a rigid individual commitment to a variety of differing approaches. The result is often inaction or a meaningless action. Can you as a leader in MAG set the example for your colleagues by energetically supporting the majority opinion or pursuing an effort that differs from your preferred approach? You must serve by your example.

It was my decision to avoid the use of names and anecdotes to illustrate how to get things done for MAG. It is at this portion of my remarks that I am sorely tempted to alter that decision. My memory retains vivid impressions of those colleagues who have been able to compromise for the welfare of MAG. My admiration and respect for these people is not diminished by the passage of time. Getting things done for MAG requires the ultimate commitment. "A true faith in the group process." Oh yes, that faith will be sorely tested not once but many times. Sadly, I must acknowledge that I can also remember those whose faith has been taxed to the point of extinction. They are no longer members of MAG or they remain in a pro forma perfunctory fashion. Getting things done for MAG requires an exquisite sensitivity to this quality of faith in those colleagues who are less involved than yourselves. They need your support and conviction in order to look past their immediate discouragement. The devil take last year's failures. When can we succeed tomorrow?

My remarks have not remotely approached the practical nuts and bolts of getting things done for MAG. To have called attention to these would have been the epitome of redundancy. AMA and MAG can and do inundate you with seminars, workshops, how-to-do-it sessions in every conceivable area of endeavor. I am also willing to agree that some of those endeavors should have never been conceived in the first place. The four items which I have chosen to call to your attention are those things that I have observed in those colleagues who have been able to do things for MAG.

To get things done for MAG, do not allow yourself to be euchred into a task for which you are not designed.

You must compromise in the Jeffersonian sense of the word. You must treat a majority of one with the same undiminished enthusiasm that you brought to the initial debate or discussion. In my judgement, the most difficult commitment to make is on behalf of your medical association.

You must compromise, you must perceive the function inherent in your personal design. You must have spirit, and you must call STAFF!

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The author discusses competition, the economy, the population, legal aspects, regulatory changes, manpower issues, technology, and selective contracting — all as they relate to medical care.

Changing Trends in the Medical Care Environment

RICHARD F. CORLIN, M.D., *Santa Monica, California**

I WANT TO SPEAK about work which our Committee on Long Range Planning has been involved in over the past several years. We have been trying to analyze and anticipate what changes will be involved in the medical care environment which will affect us and our patients in the future. We issued a report on this a few years ago and are revising and updating it and as background to it, I just want to make two statements on council and long range planning which took me some time to learn. The first is that an environmental analysis is not a static item, it is something which must be constantly updated, because the environment is changing, and the projections and anticipations may not hold true. Secondly the entire process of planning must also be evaluated. It takes awhile, particularly for those of us who have been involved in medical associations and who are used to discussing a problem, then solving it, and taking some action. We must realize that planning is *not* decision making. When I first served on a planning council, I thought we were going to solve the variety of problems with which we were presented. I eventually learned, however, that if you approach an environmental analysis from a planning viewpoint and with the idea that you are going to make a decision and take some action, it is simply not going to work out as you expect.

By 1992, approximately, 17% of the physicians in the United States will be women.

I am going to discuss eight areas related to the environment of health care delivery: competition, the economy, the population, legal aspects as they affect the practice of medicine, regulatory changes, manpower issues, technology, and selective contracting for health care.

First, the issue of competition. The pro competition bills have been around for some time. Some of them may come to pass; some of them will simply fall by the wayside. Underlining this issue, I see one key factor which has nothing whatsoever to do with any of the competition bills being considered in the legislature and that is the fact that we are entering an era of massive physician surplus. This is the reason for so many of the public and political concerns and also the reason behind the issues relating to competition.

The causes of the perceived physician surplus are (1) the massive proliferation of medical schools; (2) the large increase in the number of foreign medical graduates entering this country; (3) and the increase in the number of para-professionals who are doing work previously done by physicians.

In this country, physicians are increasing at a rate twice that of the general population; para-professionals are increasing at a rate six times that of the population. Without making a value judgment but simply making a pragmatic statement, there are going to be more physicians per patient in the future. This is going to have a significant effect on (1) physicians' incomes, and (2) the total cost of medical care. Some data suggest that fees and costs will be reduced by the physician surplus. I do not believe this is true. For one thing, total medical care costs to the community actually rise because of this increased "intensity" of treatment. Secondly, a surplus of physicians within any one given delivery

* Dr. Corlin is Clinical Professor of Medicine, UCLA School of Medicine, Santa Monica, California. This article represents a portion of his presentation at the MAG Leadership Conference at Callaway Gardens in November, 1982. Send reprint requests to Dr. Corlin at 2001 Santa Monica Blvd., Santa Monica, CA 90404.

system of care does not significantly reduce costs and may even increase costs. If we look at the legal profession, which is at least 10 years ahead of us in terms of a surplus, their fees have certainly not been reduced.

Now let us look at the economy. The percentage of our gross national product which goes to the delivery of medical care is approximately 10.4%. There are those among the general public and the legislature who perceive that this figure is too high. We can argue interminably to the contrary but the outcome is doubtful. Those who pay these costs are becoming increasingly involved, and it is they who are increasingly affecting policy. The involvement in health care by people who are paying for the care as opposed to those who are receiving or delivering it is taking the form of business coalitions. These coalitions are beginning to address the issue of health care costs and are doing so very dramatically. They are becoming increasingly effective in what they want to have done, using the same simple principal we use with our children. As long as we pay their allowance, we can have some say as to how they spend their money. When they, in this case our children, start earning their own money, they can spend it any way they please. Likewise, since the employers are paying the allowance for health care, they want more say in how this money is spent. Watching what the coalitions do is vital. They are going to have a significant effect on future economic decisions related to the delivery of health care. It is essential that we physicians work with these business coalitions.

Business coalitions are becoming increasingly effective in determining policy related to the delivery of health care. It is essential that we work with them.

Population changes are also going to affect the delivery of medical care over the next 20 years. The average age of the population in the United States now is about 30. This is expected to increase to 36 by the turn of the century. In this period also, there will be a slight increase in those under the age of 5, but that trend is not expected to continue. There will be two groups of the population that will increase most significantly in the next 20 years: those between 25 and 44, and those over 65 years of age. Both of these groups will decisively effect health care delivery.

By the year 2000, the 25-44 year age group will tend to be more technologically oriented. This group will be far better educated and more medically sophisticated than patients now. This "future" group will probably want more significant input regarding medical decisions affecting them. They will question us more, they will question costs more, and they will want to see better documentation for costs/benefits ratio for the care they receive — both from us and from hospital staff. In my opinion, this may be a greater challenge and problem for hospitals than for physicians.

The large increase in the over 65 aged segment of the population cannot be minimized. This increase will certainly drive up the cost of health care for services rendered to those people who need more care and who are less able to directly pay for that care. Most of them paid into their insurance programs before their retirement. After retirement, many will receive a combination of Medicare and some other insurance provisions afforded them on their retirement from a large corporation. The demands will become enormous when we compound this with increasing technological advances. Increasingly we will be faced with the serious question which cannot be adequately answered by physicians, and that is, who is going to pay the bill for someone who is in their last few years of life, or even the last couple of weeks of their life? This is a question that can only be answered by society, and then only after a process of evolution. Who will get the coronary bypass? Who will get the artificial heart, at an estimated cost of $140,000? Who will receive dialysis, and other extremely expensive procedures? These are difficult questions for which there are no easy answers.

There was a congressional testimony recently in which concern was expressed that 25% of Medicare money is spent in the last 2 weeks of the average person's life. This issue was simply raised and then dropped. That to me is the first shot in a discussion which is coming and will be ongoing. It is vitally relevant to us as human beings, and again it is clearly not simply a medical discussion.

Let me give you one example. I was involved recently with a 77-year-old woman who was hit by a car while she was crossing the street outside of a hospital in Santa Monica. She suffered pelvic fractures, perforated intestines, a lacerated liver, and other severe injuries. She spent approximately the last 2 months of her life in the intensive care unit, on dialysis, with respiratory assistance and a host of other life support systems. The cost of this care came to 1.3 million dollars. We cannot pretend to play God, and yet this is an issue related to cost that must continue to be addressed. Our financial resources, both as individuals and as a nation, are most certainly finite. And yet the secrets that science still holds are infinite that would continue to allow us to maintain life in the face of devastating injury and/or disease. I am not even going to try to answer the questions I have raised. But I do want to raise them as I believe they are significant and deserve our thoughtful consideration.

We are entering a time in which we are developing health services which society is going to increasingly be unwilling to provide for everyone who needs them. Do you remember when the dialysis machine first came into general use? In Seattle, there was a committee comprised of one doctor, one priest, one rabbi, two ministers, and a chief of police who decided whether those who were candidates for dialysis treatment were "socially significant enough" to receive benefit from the two machines they then had. We thought we outgrew that. But have we really? We may be evolving right back into that limiting attitude in other areas as technology continues to advance. The era ahead of us is potentially frightening; the challenge for us and for society as a whole is crucial.

There will be an increasing number of physicians going into alternative systems of medical care delivery other than fee for service, such as HMOs.

Medical care will continue to be influenced by the legal community. There are going to be far more restraint of trade concerns and questions about the open vs. the closed staff. When we wrote the first volume of our environmental analysis, our opinion was that there would emerge two classes of physicians in this country: those with hospital staff privileges and those without hospital staff privileges. In California, some court decisions place full responsibility for the action of an individual medical staff member on the entire medical staff. That is, the medical staff as a unit is liable for the action of any one of its members in a malpractice case and so is the hospital board. This is extremely serious. What we need, in my opinion, are basic changes in our credentialing and procedure awarding processes. I think what we may see is a move toward very tough quality orientation and to some extent ethical orientation for medical staff privileges as well as tighter documentation for staff privileges.

I also believe we will see that proctoring is not going to have to be retrospective review but concurrent review. Someone is going to have to be assigned to proctor the conduct of new staff members as they first begin taking care of hospital patients. This will be costly, and I would not be surprised to see fees associated with medical staff applications to pay for some of the work involved.

We need as well to continue to improve our methods of dealing with impaired, errant, and even dishonest physicians. Cover-ups are self-defeating, as they only undermine our credibility with the public. Unfortunately, however, they do continue to occur.

There are some glimmers of hope on the horizon with respect to tort reform. As the business community and insurance companies realize that they pay much of the bill for malpractice litigation, tort reform is becoming an increasingly important priority for them. We may finally be beginning to put together the coalition that will enable real tort reform to take effect. A word of caution, however. Professional liability reform or malpractice reform, call it what you will, is not really what we need because it cannot stand the test of constitutionality in many states. What we do need is across-the-board tort reform to deal with professional liability. Movements are beginning to occur in that regard.

As far as regulation is concerned, we are obviously in a period of regulatory reform and deregulation. This will probably impact on the health profession less than on commerce for the simple reason that what we do is more difficult to measure. Title licensure is being pushed in certain states. But I believe it totally does away with anything approaching an acceptable standard of care. But this is something we still need to watch very carefully.

Both we as a profession and our patients have benefited enormously by being a tightly regulated, licensed limited monopoly. I do not think it is necessarily in anyone's best interest to change that in generic terms. Most of us would not take issue with the licensing requirements that we must meet.

I do believe, however, that when we begin to see a plethora of regulations, particularly regulations which go beyond statute, we begin to have problems. As far as a variety of other regulatory programs, a horde of Health Systems Agencies (HSAs) have come and gone. Their effectiveness is questionable. In my opinion, HSAs have had nothing whatsoever to do with the reduction in the number of hospitals in this country. The HSA as a regulatory mechanism was a failure for the most basic reason: it was not needed. It was a false problem brought up by the fact that somebody invented the CAT scanner and then others said that it must be regulated. Well, it took us a long time and a couple of hundred million dollars to realize that that was not the case.

There are going to be far more restraint of trade concerns and questions about the open vs. closed staff.

PSROs basically involve the same issues. I do not want to get into whether or not you approve of them. I do believe most people's overwhelming response is that they have been cost ineffective and therefore have not served a very significant or useful purpose. Development of alternative delivery systems will provide some increase in regulation. There are provisions and regulations to protect people from

abuses by limited systems, such as Health Maintenance Organizations (HMOs) whereby they must mandate a certain minimum coverage in view of the closed panel, so that access to care is not denied. This type of regulation is in the public's best interest and will continue. We must try to get our maximum input in the development of those regulations.

I have covered most of the "manpower" issues except for a couple of points. Currently, 11% of the physicians in the United States are women. It is estimated that within 10 years that number will increase to 17%. At the present time, 28% of medical students in this country are women. This is an important demographic change. It does not appear as if a substantial number of women physicians go into part-time practice. Based on small but increasing data, women physicians provide almost the same service as men physicians. We need to address the particular needs of this growing segment of the physician population.

Increasingly, we will be faced with the serious question of who is going to pay the bill for someone who is in the last few years or weeks of their life.

There will be an increasing number of physicians going into alternative systems of medical care delivery other than fee for service. My prediction is, although I am not necessarily advocating it, that there will not be any more physicians in fee-for-service practice than there are right now. I believe the increasing number of physicians will find the medical environment difficult to break into and will therefore go into a more organized system of care. They will work on a salary for an organization, such as an HMO, increasingly giving up certain personal liberties and economic freedoms in return for the security of a reasonably well paying job. This is not necessarily good, bad, or otherwise, but I believe this will occur.

This has obvious significant implications for medical associations. Because we have an increasing percentage of the physician work force which is not in fee-for-service practice, we are going to have an increased number of physicians who look to somebody else for their paycheck. They are going to have different wants and needs of their medical associations than physicians in private practice. We need to recognize this and address programs and activities of interest to them, so that we do not lose them as medical association members. We are not the "American Association of Fee-For-Service Physicians." We are the American Medical Association, and we must recognize the fact that an increasing percentage of the physician population is going to be salaried.

Finally, I want to address selective contracting for health care. During Governor Jerry Brown's tenure in office in California, the state has had to severely cut its budget. The state's legislators wanted to cut the Medical Program, which is what we call Medicaid in California, and they had a variety of proposals. Two of the proposals were: a state rate setting commission, whereby the state would set hospital rates and allow hospitals and others to hire physicians. (California is one of the seven or eight states in which hospitals cannot hire physicians and insurance companies cannot hire physicians on a salary.)

As the business community and insurance companies realize that they pay much of the bill for malpractice litigation, tort reform is becoming an increasingly important priority for them.

The hospital association and the state medical association together fought both those bills and beat them. There were also proposals to allow selective contracting of Medical, where the state would enter into contracts with specific hospitals and doctors for fixed rates. Only those chosen hospitals and doctors could treat the Medical patients. We beat that in the legislature also. Our efforts notwithstanding, however, in something which took 11 hours from start to finish, with the state budget bypassing all policy committees, they put back the selective contracting features for Medical and pushed it through the budget committee with no public hearing. And it was made law.

Within 1 hour, the Health Insurance Association of America (HIAA) lobbyist came in and said that selective contracting for Medical would perpetuate a cost shift which we have all talked about and are familiar with. Medical underpays, therefore the surplus is put on the private insurance. We wanted the right to have private insurance companies selectively contracting also. So they put that in, too. Therefore, within one 11-hour period, we wound up with a change in the insurance law and a change in the corporate law, both of which were run through the budget committee with no public hearing.

The effect is that insurance can now be sold with either a Preferred Provider Panel (PPO) or an Exclusive Provider Panel (EPO). By way of example, let's say Aetna comes in to sell insurance. They might want to have the EPO. Actually, I think very few companies will do this, because it is not popular with the benefit managers of large corporations. They would tell their employees they could only go to particular hospitals and particular doctors, otherwise they would not pay for the medical care. The reason the EPO is unpopular, though, is that the benefit managers of the corporations are concerned about

two things: (1) the cost of medical care, and (2) the quality of care. However, they see quality differently than we do. They see it in the form of complaints from their employees. If their employees are unhappy with the medical care they receive, they will complain to the union, which will complain to the management, etc.

What may develop, however, are preferred provider panels, whereby they (the corporations) will come to you (the physician) and say, we will pay you, based upon the RVS structure, either $6 per unit for medicine, $150 for surgery, $40 for an office visit, etc. Will you agree to accept this as your payment for treating someone insured by our company? If you do, we will reimburse our employees 90% of their out-of-pocket expenses. If you do not, however, and bill your regular fees, we will only reimburse our employees 60% or 70%. So the employees still have the freedom to go where they want, but they have a strong incentive to go to the physicians and hospitals who agree to the PPO chosen by the corporation.

When this new law appeared, all of a sudden everybody who owned a pair of suede shoes was out trying to set up a preferred provider panel. We saw this as a real problem. First, because so many of these entrepreneurs were simply interested in making money and not really concerned with quality health care delivery. Second, because PPOs would disrupt practice pattern flows and potentially pit one doctor against another. For example, if they (the corporations) are paying you $40 for an office visit and the PPO charges only $35, they are going to send their employees to the group, and, unless you are willing to reduce your fee to $33.50, they will not send their employees to you.

Two terms which you will hear a lot about in the future relative to health insurance are Preferred Provider Panel (PPO) and Exclusive Provider Panel (EPO).

To deal with this situation, we at the state medical association have formed an "arms-length" organization based on some of the leaders in the medical association. We have also formed one large statewide open-panel preferred provider organization based upon usual and customary billing, and we have set up very tight peer review and utilization requirements. (Medical associations, of course, cannot be involved in setting up these provider panels because of some significant antitrust laws which I do not begin to understand. Any time I hear the word "antitrust" I know it is bad, and I just say okay.) We are subcontracting the peer review to the medical association, and we are setting up our own type utilization requirements. We have identified 1,250 procedures in the RVS book which may only be done on an outpatient basis unless specifically documented as the reason for admission, and we are going to have a major push at taking as many things as possible from the inpatient to the outpatient department and as many things as possible from the outpatient department to the office. We are beginning to look at regulatory changes that would let that happen. It will be open panel, in that any doctor in the state who agrees to abide by the peer and utilization review requirements can come in. They must agree up front that if they have a pattern which demonstrates a problem, they will be removed from the panel, but they can still see their patients. We will have to wait and see if this holds up when it is first challenged as to whether they can appeal this decision. But during the pendency of the appeal, they are off the panel. Further, they (the physicians) will agree to accept the 70th percentile of usual and customary fees as determined by the insurance company for what their current billings, not payments, are for any given zip code. We as an association are not setting fees; we are transmitting information from the insurance companies. They have agreed that the 70th percentile of usual and customary billings for any one area is what they will pay. This means that 70% of the doctors will get 100% of what they bill, that every doctor will agree to readjust their fees only once a year, and that the insurance company will agree that as fees are readjusted, they will readjust their 70th percentile of usual and customary billings. This has been well received by the medical community, because it has perceived the threat of the commercially operated preferred provider organization.

The issues concerned with preferred provider organizations and selective contracting are going to affect the entire country. Nothing that any one state faces is an isolated incident. Everybody we are dealing with — the hospital association, the health insurance association of America, the legislature, the directors of the state department of health services — are working on national legislative agendas. In some states, it will be easier to get them than in others — in the traditionally liberal vs. conservative states — but it will affect all states.

One final point: We have told physicians in California three things with respect to preferred provider organizations, things I believe will be relevant to physicians in Georgia in a year or two, and they are:

(1) Do not allow yourselves to be split up into a lot of small preferred provider organizations. We want to maintain the smallest number of the largest organizations possible.
(2) Do not allow yourselves to get into fights with hospitals.
(3) Now is not the time to panic.

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The author describes the clinical manifestations, treatment, and prognosis as they vary according to the histologic cell type of the tumor in lung cancer.

Surgical Management of Carcinoma of the Lung: Current Perspectives and Future Considerations

JOSEPH I. MILLER, M.D., *Atlanta**

Introduction

CARCINOMA OF THE LUNG continues to be a lethal and devastating disease in people in the United States. In 1982, it is projected that there will be over 120,000 new cases of lung cancer in the United States (88,000 in men, 34,000 in women) and that there will be 105,000 deaths (77,000 among men, 28,000 among women). The 5-year survival rate should remain at 8-10%, and the ratio of lung cancer incidence rate to mortality rate is projected to remain constant.[1]

Pathologic Classification

Carcinoma of the lung denotes several disease states. The clinical manifestations, treatment, and prognosis vary according to the histologic cell type of the tumor. The World Health Organization (WHO) originally listed 12 histologic classifications for lung cancer; in 1979, however, the classification system was revised to include only four major cell types: squamous cell carcinoma, adenocarcinoma, large cell carcinoma, and small cell carcinoma. Ninety percent of all lung cancers fall into one of these four types (Table 1).[1]

Squamous cell carcinoma (epidermoid carcinoma) is the most common type of bronchogenic malignancy, accounting for 50-60% of all cases. Generally central in location, 10% exhibit cavitation. There is a characteristic slow growth rate, and it is slow to metastasize, both traits lending a positive outlook for curability. Adenocarcinoma accounts for approximately 5-15% of bronchogenic carcinoma. It is generally a small lesion (less than 3 cm. in diameter), and it is peripherally located in more than 70% of cases. It may form in scars, spreads by way of the bloodstream, and generally has a moderate growth rate.

Large cell carcinoma accounts for 15% of lung cancers, the diagnosis generally evolving through exclusion of other pathologic cell types. It may occur in any location but is more often peripheral. There is a rapid growth rate with early metastasis.

TABLE 1 — WHO Classification of Lung Tumors[1]

TYPE 1	Squamous cell carcinoma (epidermoid carcinoma)	
	Variant: Spindle cell (squamous) carcinoma	
TYPE 2	Small cell carcinoma	
	a. Oat cell carcinoma	
	b. Intermediate carcinoma	
	c. Combined oat-cell carcinoma	
TYPE 3	Adenocarcinoma	
	a. Acinar adenocarcinoma	bronchogenic adenocarcinoma
	b. Papillary adenocarcinoma	bronchogenic adenocarcinoma
	c. Bronchoalveolar carcinoma	
	d. Solid carcinoma with mucus formation (considered a variant of large cell carcinoma in the original WHO classification)	
TYPE 4	Large cell carcinoma	
	Variants:	
	a. Giant cell carcinoma	
	b. Clear cell carcinoma	

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Small cell bronchogenic carcinoma accounts for approximately 15% of lung cancers. Most of the lesions are centrally located, spread by way of the blood and lymphatics, have a rapid growth rate, and metastasize early, primarily to the bone, brain, liver, or bone marrow. Small cell carcinoma is generally not considered a surgical disease.

Approach to Patient

The approach to any patient with carcinoma of the lung must consist of (1) a thorough pre-operative evaluation, (2) pre-operative staging and anatomic assessment of disease, (3) physiologic determination of operability for the projected surgery, and (4) appropriate surgery, when indicated.

The disease is considered to have three distinct phases: (1) from microscopic onset to detectability; (2) detectability to symptomatic; (3) from symptomatic to death of the patient or cure of the disease.[1]

It has been claimed that by the time a tumor is 1 cm. in diameter, it has doubled in size 30 times, contains one billion cells, and has completed three-fourths of its anticipated existence. The duration of the transition from the microscopic to the detectable phase depends on the cell type and location of the tumor. Radiographically occult, centrally located squamous cell carcinoma has been known to exist for years before symptoms appear, while small cell cancer of the lung may pass from undetectable to unresectable within a very short period of time.[1] With few exceptions, symptomatic lung cancer has a poor prognosis.

Clinical Evaluation

If the patient is symptomatic or if laboratory evidence of metastatic disease is present, then scans of liver, bone, or brain are indicated to aid in staging the patient. If no evidence of metastatic disease is found, then physiologic assessment of the patient and subsequent invasive procedures are indicated to aid in staging the patient. Routine utilization of a thoracoabdominal CAT scan is extremely helpful in the anatomic staging of disease within the chest and mediastinum, while simultaneously detecting occult lesions in the liver and adrenal glands. A standard evaluation of patients with suspected bronchogenic carcinoma is shown in Table 2.

Physiologic Assessment

Cardiac and respiratory complications are the most common sources of post-operative morbidity and mortality. For this reason, physiologic assessment of the pulmonary and cardiovascular systems in resectable patients is mandatory.

TABLE 2 — Work-Up For Cancer of Lung

Symptoms and/or chest x-ray suspicious for lung cancer

↓

History and Physical Examination
CBC | SMA-18 | EKG | CXR | UA
Skin Test: PPD; Antigen Control
Sputum for cytology | C&S
Thoracoabdominal CAT Scan
Pulmonary Function Test
Hilar oblique tomography

↓ / ↘

Symptoms or laboratory evidence of metastatic disease	**No evidence of metastatic disease**
1. X-ray and scan of liver, bone, and brain	Bronchoscopy
2. Consider biopsy to confirm	Mediastinoscopy
3. If symptoms suggest, or another primary is suspected: IVP, BE, UGI	Scalene node biopsy
	Mediastinotomy
	Needle biopsy

↓

Invasive diagnostic procedures as indicated

Assessment of Pulmonary Function

Pulmonary function tests (performed before and after bronchodilators), diffusion capacity tests, and measurement of arterial blood gases should be performed prior to any thoracic surgical procedure.[2] Specific criteria for various types of pulmonary resection are outlined in Table 3. Ratio analysis of $\frac{FEV_1}{FVC}$ and $\frac{RV}{TLC}$ and the Reichel pulmonary stress test are used predominantly for determining candidacy for pneumonectomy. Split differential perfusion scans aid in assessing tolerance for both pneumonectomy and lobectomy.[2]

Combined xenon ventilation/perfusion lung scans are performed based on the results of routine pulmonary function tests when baseline studies are less than desired for the proposed resection. These scans have been found to be extremely beneficial in determining the patient's post-operative calculated pulmonary reserve. Olsen, et al.[3] have shown that a calculated post-operative residual FEV_1 greater than 800 cc (Table 4) is compatible with reasonable ventilation reserve and ability to function comfortably with normal activity.

Assessment of Cardiovascular Function

Obtaining a careful patient history is of utmost importance in ascertaining preoperative cardiac status. Any patient with a positive history of coronary artery disease, with angina or suspected angina, or with any history of myocardial infarction should undergo cardiac exercise stress testing, including an exercise thallium scan. If there is a negative exercise test or a negative thallium scan, then the patient will generally tolerate pulmonary resection safely. If the exercise test is positive and if the pulmonary lesions appear to be anatomically and physiologically resectable otherwise, the patient should have coronary

TABLE 3 — Pulmonary Function Test

Test	Unit	Normal	Criteria for Resection: Pneumonectomy	Lobectomy	Biopsy or Segmental	Inoperable
MBC	L/min	>100	>70	40-70	40	<40
MBC	% predicted		>55	40-70	35-40	<35
FEV_1	L/min	>2	>2	>1	>0.6	<0.6
FEV_1	% predicted		>55	40-70	≥40	<40
FEF_{25-75}	L/sec	2	>1.6	0.6-1.6	>0.6	<0.6

angiography to determine the efficacy of surgically correcting the coronary lesion. In this case, it is preferable to stage the cardiac procedures, first performing a coronary artery bypass, waiting 6 weeks, and then performing the pulmonary resection. In one study, 18 patients were treated with this combined approach with a successful outcome in all cases.[4]

Thoracic resection generally is not indicated if a myocardial infarction has occurred within the previous 3 months. In a series reported by the Mayo Clinic, 25% of patients having surgery within 3 months of a previous infarct had a re-infarction. If the interval was from 3 to 6 months, the recurrence of infarction decreased to 11%, and after waiting more than 6 months for surgery, only 6% had recurrent infarctions. It should be noted that of patients who had recurrent infarction within 6 months following surgery, 60% died.[5]

Logue and Kaplan[6] state that all patients with coronary artery disease should be digitalized prior to any thoracic surgical procedure because of postoperative dysrhythmias and myocardial depression. Likewise, patients with a history of angina or infarct should be treated pre-operatively with nitrol ointment and given intravenous nitroglycerin during surgery, when indicated, to control hypertension and ischemic changes and to decrease myocardial oxygen consumption.

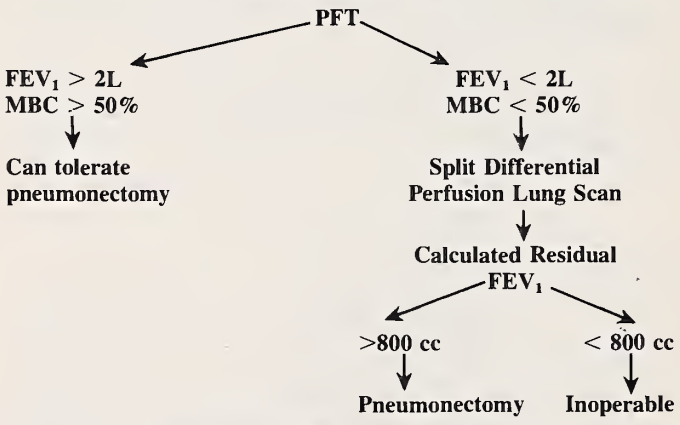
Anatomic Assessment

Assessing the anatomic extent of disease requires appropriate pre-operative staging of the patient. The staging system for classifying lung cancer as adopted by the American Joint Committee (AJC) for Cancer Staging and End Results Reporting is shown in Table 5. In this system, the letters T (tumors), N (nodes) and M (metastasis) are used with appropriate subscripts to describe the anatomic extent of the tumor.[1] Utilization of this staging process by the T,N,M system allows expression of results in a universal language.

By combining data on tumor cell type with post-surgical AJC staging, the following projections can be made for 5-year survival rates (considering deaths from all causes):[1]

1) Post-surgical squamous cell carcinoma confined to bronchial wall ($T_{IS}N_0M_0$ and $T_1N_0M_0$): 65%;
2) Other post-surgical Stage I squamous cell cancers, post-surgical Stage I adenocarcinoma, and large cell carcinomas: somewhat more than 50%;
3) Post-surgical Stage II squamous cell cancers: 35%;
4) All other post-surgical non-small cell carcinomas: 10-20%;
5) All post-surgical small cell cancers: essentially 0%.

TABLE 4 — Determining Operability for Pneumonectomy



It should be noted that some patients with a "limited" form of small cell carcinoma are known to survive 5 years, but credit seems to be due more to the intensive polychemotherapy than to surgical intervention.

Invasive Diagnostic Procedures

Bronchoscopy, mediastinoscopy or mediastinotomy, scalene node biopsy, needle biopsy, thoracoscopy, and limited thoracotomy are the most common diagnostic thoracic surgical procedures. The appropriate procedure is determined by roentgenographic, clinical, and historical evidence in the case, while at the same time weighing the risk involved. The yield of each of these is given in Table 6.[7]

Candidates for Surgical Resection

Definitive resection is currently the only approach to treatment which holds promise for long-term sur-

TABLE 5 — Staging of Lung Cancer[1]

PRIMARY TUMOR	
T_x	Malignant cell in cytology; site undetermined
T_0	No evidence of primary tumor
T_1	Tumor ≤ 3 cm. in size; surrounded by tissue
T_2	Tumor > 3 cm. in size
T_3	Tumor of any size with extension to chest wall, parietal pleura, diaphragm, mediastinum, or within 2 cm. of carina
NODAL INVOLVEMENT	
N_0	No lymph node metastasis
N_1	Metastasis to peribronchial or ipsilateral hilar region only
N_2	Mediastinal lymph node metastasis
DISTANT METASTASIS	
M_0	No distant metastasis
M_1	Distant metastasis present
STAGE GROUPING	
Stage I	$T_1N_0M_0$ *
	$T_1N_1M_0$
	$T_2N_0M_0$
Stage II	$T_2N_1M_0$
Stage III	T_3 with any N or M
	N_2 with any T or M
	M_1 with any T or N

* T = tumors; N = nodes; M = metastasis

vival for non-small cell carcinoma of the lung. The criteria for definitive resection relate to: (1) the biologic nature of the tumor, (2) the anatomic extent of the disease, and (3) the physiologic status of the patient.

Physiologic status permitting, all patients with Stage I and Stage II disease with squamous cell carcinoma, adenocarcinoma, and large cell carcinoma, as well as selected patients with Stage III disease, are considered candidates for definitive surgical resection. According to Mountain, et al.,[8] "Final selection of the specific operative procedure must take place at the time of exploration, but the probable extent of the resection is carefully planned preoperatively, depending on the patient's cardiovascular and pulmonary status." The location of the tumor and stage of disease usually dictate the procedure of choice.

Squamous cell carcinoma is considered to have the best prognosis of the four types of bronchogenic carcinoma

Absolute contraindications to resection are (1) malignant pleural effusion, (2) metastatic disease outside the thoracic cavity, (3) superior vena caval syndrome, (4) paralysis of the recurrent laryngeal nerve, (5) oat cell carcinoma, and (6) a positive mediastinoscopy, with one exception, ipsilateral intranodal squamous cell carcinoma confined to the tracheobronchial angle nodes.

TABLE 6 — Diagnostic Procedures

Procedure	Diagnostic Yield (%)
Fiberoptic Bronchoscopy	
Peripheral lesion	30-50
Central lesion	70-80
With transbronchial lung biopsy	80-90
Mediastinoscopy	
Peripheral lesion	5-10
Central lesion	70
Mediastinotomy	
Left upper lobe lesion	50-60
Scalene Node Biopsy	
Nonpalpable node	10-20
Palpable node	80
Needle Biopsy	
< 3 cm.	50
> 3 cm.	80
Thoracoscopy (for pleural effusion)	95

Surgical Procedures

Segmental resection is indicated for small peripheral lesions (usually less than 3 cm in diameter for Stage I disease) and for patients with compromised cardiopulmonary status. Relative contraindications are T^2 lesions or lesions which cross an intersegmental plane. Mortality for segmental resection is less than 0.5%.[7]

Lobectomy is currently the operation of choice for carcinoma of the lung. This procedure is indicated when technically feasible for Stage I and Stage II disease as well as for some Stage III lesions. The mortality rate is approximately 1.3%.[7]

Pneumonectomy is indicated with more extensive disease, generally with hilar involvement. The mortality rate is approximately 5%.[7]

As a rule, patients with Stage III disease are not candidates for definitive surgical resection. Exceptions to this include some central lesions and hilar nodal involvement, Pancoast tumors, and certain lesions with chest wall involvement.

Results of Surgical Therapy

Current reported surgical results for Stage I squamous cell carcinoma reveal 50-60% 5-year survival rate. Stage I adenocarcinoma and large cell carcinoma have a reported 35-50% 5-year survival rate. Survival for Stage II and Stage III carcinoma, however, is markedly decreased and varies from 10% to 35%, depending upon the cell type.[8]

The post-surgical staging of a patient with non-oat cell bronchogenic carcinoma is probably the major determinant in the prognostic future of the patient. Any nodal involvement encountered at thoracotomy for any cell type of carcinoma is a cause of major concern. Squamous cell carcinoma is considered to have the best prognosis of the four types of bronchogenic carcinoma. Adenocarcinoma and large cell

carcinoma have similar but intermediate survival rates, and small cell carcinoma has basically no 5-year survivors. If a patient has $T_1N_0M_0$ Stage I squamous cell carcinoma, his probability of surviving 5 years is 80% or better.

Post-Operative Therapy

Long-term survival in non-oat cell bronchogenic carcinoma is dependent on the effectiveness, applicability, and availability of definitive surgical therapy. The effectiveness of such therapy is jeopardized by the presence of occult metastatic disease which is not manifest at the time of treatment. Conversely, the applicability of resection is compromised in those patients whose disease is systemic at the time of diagnosis. The end results of surgery in terms of cell type and anatomic extent of disease provide some insight into the nature of failures following apparently complete resection and enable identification of specific subgroups that are targets for adjunctive therapy.

Definitive resection is currently the only approach to treatment which holds promise for long-term survival for non-small cell carcinoma of the lung.

The data of Mountain, et al. illustrates that the failure rate following curative surgery increases as the magnitude of the tumor burden to be resected increases, and it varies according to cell type.[9] It has been estimated that the failure rate following curative resection for bronchogenic carcinoma is approximately 50%, and that the majority of these failures tend to occur within the first 2 years following resection for cure. It has also been shown that in the majority of those patients who have relapses, the first manifestation of recurrence is distant metastasis. Currently, there is no absolute proof that postoperative radiotherapy, chemotherapy, or immunotherapy alone or in any combination will prolong long-term survival.

Radiation therapy is generally recommended in high doses for cure to the mediastinum, remaining ipsilateral lung, and supraclavicular nodal area in patients with squamous cell, large cell, or adenocarcinoma resected for cure in whom microscopic disease is found in the peribronchial nodes. In addition, radiation therapy is offered for cure in medically inoperable patients and in those refusing surgical resection. It is offered as a palliation procedure in patients who have metastatic bone pain, obstruction of a major bronchus, and/or superior vena caval syndrome.

Adjunctive immunotherapy with BGC has produced varying clinical results but is not of sufficient promise to be recommended in routine clinical practice. There is presently no good chemotherapeutic regimen for squamous cell or large cell carcinoma. Various experimental chemotherapeutic protocols for adenocarcinoma seem to offer some degree of hope for prolonged survival when recurrent metastatic disease is found.

Conclusion

Surgical resection remains the only therapy that offers hope for long-term cure in patients with non-small cell bronchogenic carcinoma. The future for treatment of bronchogenic carcinoma lies in a multidisciplinary approach involving resectional surgery combined with chemotherapy and/or immunotherapy. Until the disease is eradicated, our goals as physicians in the management of this disease should be "to cure sometimes, to help often, to comfort always."[10]

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The History of Exercise in the Practice of Medicine

GERALD F. FLETCHER, M.D., *Atlanta**

THE HISTORY OF EXERCISE relating to health and the practice of medicine is to some degree becoming cyclic or repetitive. Before the era of machines and conveniences of life, our population, by necessity, was much more involved in physical activity and physical labor. Then, with the industrial revolution and the evolution of our mechanized society, people became less physically active and through the years the sedentary way of life became more the rule rather than the exception. Within the last 10 years, as the public has become more health conscious, there has been a resurgence of interest in exercise and physical activity. This is in great part due to the belief that increasing one's physical activity is a significant factor in a successful "preventive health" program.

Before Christ (B.C.)

The history of exercise relating to medicine began in the early days before Christ. There are a number of Biblical references to the practice of medicine; however, little or no reference is made specifically to exercise and medical practice. The most precise statement with regard to exercise and health is in the Bible in I Timothy 4:8:[1]

> "For bodily exercise profiteth little; but godliness is profitable unto all things, having promise of the life that now is and of that which is to come."

This portion of text likely serves to emphasize that since bodily training is of such slight value, men should devote themselves to religion.

Other references (B.C.) to exercise in early times include the following:

> Cicero (106-43 B.C.) said, "Exercise and temperance can preserve something of our early strength even in old age."[2] Hippocrates (460?-377 B.C.) stated, "Fat people who want to reduce should take their exercise on an empty stomach and sit down to their food out of breath. . . . Thin people who want to get fat should do exactly the opposite and never take exercise on an empty stomach."[3]

Anno Domini (A.D.) — Galen

One of the earliest documents relating specifically to exercise and the practice of medicine was *Galen's Hygiene* which is recorded in detail by Green[4] in a translation in 1951 and paraphrased as follows:

> Galen practiced medicine in 151 A.D. He wrote on many aspects of exercise with particular attention to uses, values, purposes, time, method, techniques, and varieties of massage. He referred to the theories of Theon and Hippocrates and mentioned the definition and amount of massage and exercise. He referred specifically to varieties of "vigorous" and "swift exercises."
>
> As an early attempt to prescribe exercise, three forms of rocking for babies were devised by nursemaids — in cradles, in swings, and in their own arms. Asclepiades opposed and clearly condemned exercises, and though Erasistra-

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tus cautiously approved but otherwise agreed with Asclepiades, almost all other physicians approved them not only for satisfaction but for health. Three principal kinds of exercises were described and the same number of differences of motion; for it was felt that we move either of ourselves, or through others, or by means of drugs. But children can first move themselves when they begin to creep and even more when they begin to walk.

It was felt by Galen that he should not refute the trifles of sophists, but teach what is useful for health. He felt that the habit of the mind is impaired by faulty customs in food, drink, exercise, signs, sounds, and music. Therefore, the hygienist must be skilled in all these, and must not consider that it concerns the philosopher alone to mould the habit of the mind.

It was felt necessary to preserve bodily warmth within the limits of health and that is preserved by moderate exercise not only of the body but of the mind.

The statement was emphasized and enunciated by Hippocrates in his Aphorisms, when he wrote: "Work should precede food"; and in the sixth volume of his *Epidemic Diseases:* "Work, food, drink, sleep, sex, all in moderation." For he designated the degree of everything by the term *moderation.*

Galen related that no one had anything more to say about the effects of rubbing than Hippocrates in his book on therapeutics when he said that the body is constricted by hard rubbing (massaging), relaxed by soft, thinned by much, and thickened by moderate.

Galen related that it was felt wise to begin with work, considering first whether work and movement and exercise are the same; or whether work and movement are the same, and exercise different; or whether movement is one thing, and work and exercise are the same. It was felt that not all movement is exercise, but only when it is vigorous. But since vigor is relative, the *same movement might be exercise for one and not for another.* The criterion of vigorousness is change of respiration; those movements which do not alter the respiration are not called exercise. This, therefore, was commonly called exercise or gymnastics, from the gymnasium or public place to which the inhabitants of a city come to anoint and rub themselves, to wrestle, throw the discus, or engage in some other sport.

The term work seemed to have the same significance as that designated by exercise; for those who dig, and those who reap, and those who ride, are both toiling and exercising, under the common designation of exercise.

The uses of exercise were felt to be twofold — one for the evacuation of the excrements, the other for the production of good condition of the firm parts of the body. Since vigorous motion is exercise, these three things result from it in the exercising body: — hardness of the organs from mutual attrition, increase of the intrinsic warmth, and accelerated movement of respiration. And because exercise purges the ducts and evacuates the excrements, it is better for it to be taken before meals.

Therefore, in order that these things may be done, it was felt necessary to warm the whole body moderately by rubbing it with muslin and then with oil. However, rubbing should not be so hard as to harden the body being prepared for exercise, but rather to predispose to action, to maintain tone, and to avoid the relaxation which follows gentle rubbing.

Galen related that no one had anything more to say about the effects of rubbing than Hippocrates in his book on therapeutics, when he said that the body is constricted by hard rubbing, relaxed by soft, thinned by much rubbing, and thickened by moderate. And his words are as follows: "Rubbing has the effect of relaxing, constricting, thickening, and thinning; hard rubbing constricts, soft relaxes, much rubbing thins, and moderate thickens."

It was felt that the three different varieties of massage according to quality, combined with the three different varieties according to quantity, make nine combinations: six which were mentioned by Theon:

QUALITIES	QUANTITIES
Firm	Little
	Much
	Moderate
Gentle	Little
	Much
	Moderate
Moderate	Little
	Much
	Moderate

Much detail was related to massage. It was felt that sometimes in itself it produces benefit in our bodies; and sometimes it assists other beneficial agents, as Hippocrates said about bandaging: "some bandaging cures in itself, some assists other curative agents." But massage preparatory for exercise, and that under-

taken after exercise, assists the exercise — the former opening the pores by warming moderately and liquefying the excrements in the flesh and softening the solids. This is called preparatory massage, and the latter apotherapeutic massage.

Another consideration was emphasized namely in what season of the year and in what part of the inhabited world the person is to exercise. The building in which he is going to exercise should be warmer or cooler than the common atmosphere of the whole city on that day. Moreover, in winter and in summer the same should be provided for him (i.e. warmth in winter and coolness in summer) in order that the body may be exactly of mean temperature at the time of the massage.

"Those who think they have not time for bodily exercise will sooner or later have to find time for illness." (Edward Stanley)

It was further emphasized that the exerciser must not be too ambitious, so that he is still eager to exercise when his strength is already weary, nor lazy so as to give up while still able to work. It is not only the body but the mind of such a person which we are to train.

Consideration was given to the varieties of exercise such as wrestling, pancratium, boxing, running, and whatever else there is of this sort, some of these being exercise alone, and some not only exercise but also work. Other exercises, in addition, were pitylism, ecplethrism, shadow-fighting, acrocheirism, leaping, discus-throwing, and exercising the body with the corycus and with a ball (either small or large) and with pulling-ropes. Exercise and work are digging, rowing, ploughing, pruning, burden-bearing, reaping, riding, fighting, walking, hunting, fishing, and whatever other things men practice for a living, either as artisans or ship-building, or plough-making, or manufacturing any other such instrument of peace or war.

It was felt that the common feature of all exercise is the increase of heat produced by it in the animal. For bodies grow warm both from baths and from washing with warm waters, and from the warm seasons of the year, and from insulation and from heating by fire, and from being rubbed with warm drugs. But all such forms of warmth are from without, not from within, nor do they arise and increase from an intrinsic source.

Galen called a vigorous exercise one which exercises forcibly without speed, and a violent exercise one which exercises forcibly with speed. And likewise, whoever, seizing a rope or some high piece of wood, remains hanging from it as long as he can, is exercising robustly and vigorously, but not swiftly.

It was said that the well-known Milo exercises himself, sometimes offering himself to anyone who wished to tear and remove him from his seat (but this would be chiefly an exercise of the legs); and sometimes, if he wished to exercise his hands, ordering them to unclasp his fist.

Consideration was made to exercises which are swift, but not vigorous or violent. These are running, shadow-fighting, hand-wrestling, punch-bag, and small-ball both standing and running. Of this sort also are ecplethrism and pitylism. Ecplethrism is when anyone, running back and forth within the length of a plethrum (100 feet), turning to neither side, shortens the distance a little each time, and ends by coming to a stand at one pace. Pitylism is when anyone moves very quickly backward and forward, going on the tips of his toes and stretching up both hands; and usually near a wall, so that, if ever they trip, they can easily straighten themselves up by touching the wall.

It was also felt possible to perform a swift exercise with the legs alone, standing in one place, and then to jump, drawing one leg back and advancing the other alternately and quickly, changing legs each time.

Walking and running were considered specific exercises of the legs, acrocheirism and shadow-fighting of the arms and of the loins bending repeatedly forward and backward or lifting something heavy from the ground or supporting something continuously in the hands. Deep breathing was the specific exercise of the thorax and lungs; so is phonation and the use of all the phonetic organs.

Some motions, however, were felt to be mixed, like those of horseback riding. For it is not the same riding in vehicles, and especially reclining in litters, as when riding on a horse. One is merely shaken by its movements, and one must hold the back straight and grip the horse's flanks firmly with both thighs, extend the legs, and look forward. In the latter, both the vision is exercised, the neck works, and the viscera are shaken.

Galen felt the trainer knows all the movements made in the gymnasium but is ignorant what each movement can accomplish. Therefore, the trainer is the attendant of the gymnast, such as the cook is of the physician.

Therefore, a great deal of very important and scientifically correct (as applied today) reference was made to exercise in the time of Galen. Much was applicable, however, to the specialty of sports medicine and also to massage, which today is not included to a great degree in physical activity programs in this country. Nonetheless, many of the aforementioned basic principles are employed today in the resurgence of exercise activities in the field of health care.

In the period of time from Galen (151 A.D.) to Osler (early 1900s), data and information is recorded in quotes. Most of this is not of primary medical derivation but is appropriate to the topic:

Benjamin Franklin (1706-1790): "Use now and then a little exercise a quarter of an hour before meals, as to swing a weight, or swing your arms about with a small weight in each hand; to leap, or the like, for that stirs the muscles of the breast."[5] "If, after exercise, we feed sparingly, the digestion will be easy and govern the body lightsome, the temper cheerful, and all the animal functions performed agreeably."[12]

Thomas Jefferson (1743-1826): "Not less than two hours a day should be devoted to exercise."[6]

George Santayana (1863-1952): "He found escape . . . above all in bodily exercise. This was destined to be his sovereign medicine and sheet-anchor throughout his short life."[8] The sovereign invigorator of the body is exercise, and of all exercises walking is the best.[9]

"Patients should have rest, food, fresh air, and exercise — the quadrangle of health." (Sir William Osler)

Edward Stanley, Earl of Derby (1826-1893): "Those who think they have not time for bodily exercise will sooner or later have to find time for illness."[10]

John F. Kennedy (1917-1963): "The Greeks understood that mind and body must develop in harmonious proportions to produce a creative intelligence. And so did the most brilliant intelligence of our earliest days, Thomas Jefferson, when he said, not less than two hours a day should be devoted to exercise. If the man who wrote the Declaration of Independence, was Secretary of State, and twice President, could give it two hours, our children can give it ten or fifteen minutes."[11]

Mishneh Torah "Hilchoth De'oth": "Anyone who lives a sedentary (life) and does not exercise or he who postpones his excretions or he whose intestines are constipated, even if he eats good foods and takes care of himself according to (proper) medical principles — all his days will be painful ones and his strength will wane."[13]

Sir William Osler (1849-1919): "Patients should have rest, food, fresh air, and exercise — the quadrangle of health."[14]

Francis Beaumont (1584-1646) and *John Fletcher* (1579-1625): "As men do walk a mile, women should talk an hour after supper: Tis their exercise."[15]

Giorgio Baglivi (1669-1707?): "Length of life does not depend so much on a good physical constitution as it does on the best use of the six nonnatural things,* which if we rule aright, we shall live long and healthy lives: to divide the day properly between sleep and waking; to adjust our air to the needs of the body; to take more or less food and drink according to our age, our temperament, and whether we live an active or inactive life; to take exercise or rest according to the quantity of our food and whether we are lean or fat; to know ourselves, and be able to rule our emotions, and subject them to our reason. Whoever handles these wisely will live long and seldom need a doctor."[16]

James Thomson (1700-1748): "Health is the vital principle of bliss, and exercise of health."[17]

John Leak (1720-1792): "The poor female cottager, who uses exercises in the open air, who eats the coarse, but wholesome bread of industry, and drinks from the cooling stream, is seldom troubled with those maladies which afflict the rich and indolent, undone by the abuse of plenty."[18]

Historically, the next phase of exercise evolved in 1818 when William Cubitt, a British civil engineer, designed an elonged "stepping wheel" on which dozens of prisoners would work side by side. In accord with this, "treading the wheel" for punishment became prevalent throughout English prisons.[19] In 1846, however, because reformers considered treading the wheel a cruel, inhumane, and unhealthy practice, Edward Smith began to investigate physical performance by utilizing new physiologic techniques during treadmill exercise.[20] These studies were the first systemic inquiry into the respiratory and metabolic response of the human to muscular exercise and provided the groundwork for extensive studies that have followed in the evalua-

* In medieval medicine, the six "nonnatural" things (things which caused health or disease and were not actual parts of the human body) were meat and drink, retention and evacuation, air, exercise, sleep and waking, and passions of the mind. Baglivi mentions all but the second.

tion of exercise performance in patients with coronary heart disease. Smith's early studies included measurements of inspired air, respiratory rate, stroke volume, pulse rate, and oxygen production. By 1857, measurements were made for other types of exercise including swimming, rowing, and horseback riding.[21]

With the acquisition of exercise habits early in history and the insight into methods of evaluation of exercise performance, observations[22] began to reveal a higher mortality rate in people with sedentary occupations compared to those who were physically active. These observations were to be the forerunners of more studies relating physical inactivity to mortality and morbidity from coronary heart disease.

As history has been influential in other fields of medicine, it appears that such trends have also developed in the relation of exercise to coronary artery disease. Although little or no specific mention is made of coronary heart disease in the preceding paragraphs, it can likely be assumed that historically, as is certainly true today, a considerable percentage of human mortality was secondary to diseases of the heart and blood vessels, especially coronary artery disease. Sudden death has been a subject of recent interest; this most likely was prevalent in early history and, as is thought to be true today, was likely related in many instances to undiagnosed coronary atherosclerotic disease.

In 1914, Sir William Osler, in the eighth edition of his book, referred to exercise and its place in management of certain disease states:[23]

— "The most important element of all is graded exercise, not on the level but up hills of various grades. The distance walked each day is marked off and is gradually lengthened. In this way the heart is systematically exercised and strengthened."

— Exercise and the treatment of *constipation:* "Exercise in moderation is helpful."

— Exercise and *tuberculosis:* "It is found that as a rule the patient with fever does best at rest and exercise should only be taken after an afebrile period and then very gradually. It has long been known that following exercise the temperature is raised. The febrile patient is regarded as one in whom the auto-inoculation is excessive. To overcome this, the patient is immobilized in bed as much as possible and not allowed to make any movements whatever. The effect of this if often remarkable in reducing the fever. Once afebrile, the principle element in the treatment is the induction of auto-inoculation by exercises which has very much the same effect as a dose of tuberculin. A scheme of graded labor has been devised which has many advantages in sanatorium life, and the results obtained from it are certainly very gratifying."

Later in the 1900s, Dr. Paul Dudley White became part of history, and his influence continues in both professional and lay circles. He was a strong advocate of exercise and believed that exercise was beneficial, both physiologically and psychologically. He felt that walking was beneficial, especially because of its "venous squeezing" effect; that the lower extremity veins have valves and that walking helped move the blood in the veins and provoked better circulatory dynamics. He advocated that people who walk a great deal have less early arteriosclerosis. He felt that people today have a life that is much too easy — using elevators instead of stairs and having lunch brought in rather than going out. He felt that "work alone never killed a man unless he is already sick."

Doctor White advised walking as probably the best exercise and was averse to activities with weight lifting. His own personal exercise included climbing stairs, walking to lunch, gardening, cutting trees, splitting logs, shoveling snow, and "working in the soil."

He believed that "one feels so much better with exercise" and his formula for long life was to "work hard mentally, physically, and spiritually." He referred to our easy way of living as a "real pity." He felt that our ancestors were in better physical health because of their active lives spent in clearing the forests and plowing the land. He felt that exercise was the "best tranquilizer there is." In farewell comments to his many friends and acquaintances, he was never know to say "take it easy" but rather to say "take it hard."[24]

Over the years, it has become generally accepted that those persons who have physically active occupations enjoy better physical health. Such an assumption, however, is not totally supported by sound evidence. Isolated case histories such as that of Clarence DeMar,[25] the marathon runner of the early 1900s, provide striking examples of the benefits of the long-term physical conditioning. DeMar participated in marathon races for forty-nine years, and at his death (of metastatic rectal cancer) at age seventy, his coronary arteries at autopsy were two to three times the normal diameter.

Therefore, the history of exercise relative to health and the practice of medicine began in early Bible times before the time of Christ, and evolved through early historic times into the 1800 and 1900s. Reference is made mostly to the beneficial effects of exercise but some negative data are explicitly recorded. In early times, before the days of machines, motorized vehicles, and other mechanized devices,

man spent much of his day in a physically active state — walking, working the soil, lifting, working with the hands, and being involved in other physically active endeavors. In the intervening decades, man has become relatively inactive because of the development and progress of our society. This progress and modernization has provoked inactivity, improper dietary habits, obesity and is often associated with and aggravated by high blood pressure, coronary artery disease, diabetes mellitus, and other systemic disease.

Whether or not we believe that "history repeats itself," we are now witnessing in the 1980s a renewed interest in exercise and physical activity. The American public is becoming increasingly conscious of their physical appearance and body weight. It also seems that a more intense effort in proper dietary intake is apparent. With this current public attitude, we are now in an era of more healthy living which will result in alleviation and moderation of certain diseases that are pandemic in our population.

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From Holland With Love

EVELYN WARD GAY, *Decatur**

THE MARCH 16, 1968, issue of *Saturday Review* carried these words: "Willem van der Zalm came to Georgia to join an international venture in chemicals. His children got a lot in the bargain." One of the photographs accompanying the statement showed a pretty young woman engrossed in her work at the Medical College of Georgia.

That young woman is now Dr. Theodora Vanderzalm, a prominent Augusta physician who is active in local, state, and national medical organizations — proof that Georgia also received a large share of the bargain.

Dorien, as she is known to her family and friends, has come a long way from the small coal mining town of Geleen in The Netherlands where she grew up, but the effects of the transition are barely noticeable today. She is often mistaken for a born-and-bred Georgian, for there are few traces left of the Dutch accent which she brought with her 20 years ago.

Some of the hardships of World War II, which had begun for the van der Zalm family with the German takeover of their homeland in 1940, were still fresh memories, however, when they arrived in the United States in 1963. Her father, a chemical engineer with a fertilizer plant, had decided to evacuate his family when they found themselves living in the path of Allied Forces' planes as they pursued the enemy. Her mother and the two small children (Theodora was the older) had gone first to a grandmother's home in northern Holland just south of the Waal River, while her father had remained at his job. They were moved later to a tiny village outside Rotterdam, a city which had experienced the full fury of German bombs in 1940. A farming family there had volunteered to take them in.



Theodora van der Zalm as a child in Holland.

Living was difficult for the Dutch people during those war-torn years under German occupation. The winters were cold, food and clothing were scarce, and many of them died of starvation. But the van der Zalms were blessed. They survived because of the kindness of strangers who shared with them their home and farm products. And another baby was born into the van der Zalm family.

Dr. Dorien Vanderzalm now recalls only a few instances during those months when she was small and the family members were separated by the war. One memory she does have is of herself as "a bad little girl who threw her wooden shoes." The wooden shoes she wore, she says, were the only shoes she had. But they were tough, and they kept her feet warm.

Another vague recollection is of her father who came occasionally to visit the family after pedalling

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his bicycle more than 100 miles from Geleen, where he shared the family home with some American officers.

"I remember one time he brought us some chocolates the officers had given him," she says. "But I didn't remember that he was my daddy. I told him I had a daddy back in Geleen."

In the spring of 1945, when Holland was liberated by the Allies, the family returned home. Life in Geleen thereafter, says Dorien, was not too different from life in America. The people wore much the same type clothes, and what other people think of as "Dutch costumes" were reserved mostly for the benefit of tourists. The towns were smaller; the houses were closer together and more compact.

The school system, explained Dorien, is different from that in the United States. Elementary school extends over the first 6 years, but at that point choices must be made as to the direction the next 6 years will take. Three general tracks are available: vocational, scientific, and classical. Dorien went into a classical track which required that she take several languages — German, French, English, Latin, and Greek — in addition to Dutch. The last 2 years of this period were divided again into scientific and language tracks. She chose physics, chemistry, and advanced mathematics.

Dorien says she still speaks Dutch with her parents, who have retired and live near her in Augusta. But she is very appreciative of the different languages which she learned during her early school years. They were helpful to her as she began her 6-year study of medicine at the age of 18 at Leiden University, one of the world's oldest and most prestigious schools, located about 120 miles from her home. Organized in 1575, the university (previously spelled Leyden) had graduated many famous physicians over the centuries. When Dorien was there, about 1/3 of the student body were women. The first subjects she took were organic chemistry, zoology, physiology, gross anatomy, and histology, a curriculum somewhat resembling the United States system of pre-medical education, but more advanced. The textbooks were printed in French, German, and English.

In 1963, when she was 2½ years into her medical studies, her parents decided to emigrate to the United States where her father, who was associated with the Dutch State Mines, was to join in a project to design and build a nitrogen fertilizer plant in Augusta. The family now consisted of the parents and 5 children. All except one son came to live in Evans, Ga., just outside Augusta.

Dorien remembers well some of the family's experiences after they left Holland. The voyage to America aboard a freighter with about 30 other passengers was long and hard. It was winter, and the sea



A teen-aged Theodora van der Zalm shows off her wooden shoes by a canal near her childhood home.

was stormy and rough, causing much seasickness in the family. Her father, who had visited in Augusta previously, told them glowing stories about how they would love the climate in the South. It would be warm, he said, and they would never have to endure severe winters again. But it was a cold January when they arrived, and they nearly froze because they had not brought any warm clothes.

Another problem, she recounted, was their inability to communicate with the natives. One day the children set out with their mother to fill the family car with gasoline. The father had given them $10 and told them simply to ask the man at the station to give them $10 worth of gasoline. They did as they were told, unaware that at that time the gas tank wouldn't hold $10 worth of gas. Obviously recognizing them as newcomers who were unable to speak English fluently, the man shook his head, filled the tank, and gave them back their change.

It didn't take Dorien long, however, to learn her way around Augusta. Her main objective was to re-enter medical school. After spending a year taking extra classes and satisfying all test requirements, she was accepted as a student at the Medical College of Georgia, where only six of her classmates would be women. She picked up the English language easily and was graduated with an M.D. degree in 1967. A rotating internship followed at Talmadge Memorial Hospital. She then spent 1½ years at the same hospital as a resident in general radiology before moving to Atlanta for the remainder of her residency at the Emory University School of Medicine. During the final year of her training she was in the Pediatric Radiology Department at the Henrietta Egleston Hospital for Children.

In December of 1969, Dr. Dorien Vanderzalm married a fellow Augusta physician, Dr. Rufus Maloney, who had joined the Emory University School of Medicine's Department of Urology. When she completed her residency at Emory, she became a member of the staff at the children's hospital. In



Drs. Vanderzalm and Maloney enjoy flying their own plane to medical meetings.



Dr. Dorien Vanderzalm and her husband, Dr. Rufus Maloney, at their home in Augusta.

1973, she returned with her husband to Augusta where he entered the practice of urology, and she at first worked at the Veterans Administration Hospital in general diagnostic radiology. Later she was named chief of the Pediatric Radiology Section at Talmadge Memorial.

Since that time she has been active in several medical groups. For 4 years she served as secretary of the Georgia Radiological Society, and in 1981-1982 she was president of that organization. Now an associate professor at the Medical College of Georgia, she is on the Committee on Resident Information for the American College of Radiology, secretary-treasurer of the Richmond County Medical Society, a position she has held for 2 years, a delegate from her county medical society to the Medical Association of Georgia, and a member of the promotion committee of the medical college for medical students who will graduate in 1985. She served on the Admissions Committee of the medical college for 3 years, and recently was a member of the search committee to select a chairman for the Department of Pediatrics, in which she holds a joint appointment.

Dr. Dorien Vanderzalm and her husband, Dr. Maloney, who holds licenses in pharmacy and medicine, share several hobbies. Flying their own airplane, a Cessna Skyhawk 172 4-seater, has been both a pleasure and a necessity. It has made attending distant meetings possible as they try to juggle two busy schedules.

Flying lessons were not on Dorien's mind, however, when they purchased the airplane, she says. In fact, she was "scared to death" of flying, but she soon decided that she needed to know how to land the airplane if anything happened to her husband. She began taking formal flying lessons and had learned to handle the airplane when he did, indeed, begin to suffer from heart problems. In 1979, he had by-pass surgery and because of this lost his flying certificate. She since has taken instrument flying lessons and often flies alone, but when he is with her, he does the navigating while she operates the airplane. He also has had to give up the practice of urology and is involved in a new undertaking, a residency in radiology, which entitles him to become a junior member of the Georgia Radiological Society along with his wife.

The two doctors also enjoy photography and music. She plays the piano and he strums the ukelele.

editorials
editorials
editorials

Editorial or Advertisement?

THE MAG *Journal* has published two articles in the past year delineating the pros and cons of various subspecialty ideations. One may assume that future issues will carry more of the same, and I look forward to reading the debates on the values of varying medical and surgical treatments for similar illnesses. Perhaps the board in its wisdom can have the authors of these views present them in a form without sanctimoniously suggesting that only their select group is without parallel in this area. There exist many areas of specialty overlap. Medicine is at best a complex and inexact science; surgery substitutes one pathology for another, hopefully with improved quality of life for the patient; medication improves and occasionally cures an illness, hopefully without excessive side effects. To claim more, we as physicians expound ignorance or arrogance. Proven theories are few while unproven ones proliferate.

May I suggest that we all present our clinical and laboratory findings in an objective manner, devoid of professional advertising and self enhancement. Doctors of Medicine face greater threats from outside our domain than from within. While our approaches may differ and our feelings run strongly, there is a far greater need for unity of purpose both for our patients and our profession.

J. R. B. Hutchinson, M.D., F.A.C.S.
Vice President — American Academy of Otolaryngologic Allergy
1462 Montreal Rd., Ste. 403
Tucker, Georgia 30084

Speak Out On The FTC

IT IS IMPERATIVE that we physicians act now to give the public and the Congress accurate information about the false claims and assertions made by the Federal Trade Commission (FTC) in its attempts to control our profession. Congress will soon be deciding whether the FTC can continue its inappropriate, heavy-handed role as self-appointed arbiter of the medical profession and other state-regulated professions.

Some misguided consumer groups, much of the media, and the FTC, itself, have been attempting to mislead the public about the need for the FTC to police the medical profession — and they may succeed in selling this bag of nonsense to members of Congress unless we act now.

We know the FTC has not solved *any* problems involving the medical profession that could not have been handled more appropriately, more efficiently, and more economically by another agency. We know, in fact, that some of the so-called problems the FTC *claims* to have solved were cases in which charges were unfounded to begin with or cases that had been straightened out on the local level before the FTC stepped in.

We know that FTC charges against the medical profession and the fishing expeditions the FTC has undertaken have cost taxpayers millions of wasted dollars. The costs of defending against these charges have also led to diverting medical society funds from worthwhile activities — more wasted dollars.

We know the American people do not want Washington interfering in their personal medical care. They want local problems settled locally — as they have been and are being solved locally. They want their local and state medical societies to continue to be responsible for acting in their behalf when they need advice about appropriateness of treatment or fees or about false and misleading advertising — claims that can be accurately evaluated only by competent physicians.

We know that the U. S. Department of Justice, state attorneys general, licensing boards, and civil courts are appropriately dealing with complaints against physicians and that this proves there is no need for the FTC to intercede.

Yes, we know these things. But that is not enough. Now we must respond to inaccurate media reports. We must write, wire, and phone members of Congress to clarify the issues and help them make the right decisions on bills pending that will determine the future jurisdiction of the FTC.

Each of us in the medical profession must become knowledgeable about the myths and the facts in this issue (Re-read Dr. Edgar Woody's editorial in the November, 1982, *Journal.*) — and all of us must take the time to speak out. Both our society (association) and the AMA can supply you with information on the issue if you need to learn more. Don't put off acting. Please set aside some time today to do your part.

Charles D. Hollis, Jr., M.D.

The views expressed on the Editorial Page are not necessarily those of the MAG unless so stated.



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Interpreting the Composite State Board of Medical Examiners' Statutory Authority to Discipline Physicians on the Basis of Conduct Unrelated to the Practice of Medicine

ROBERT N. BERG, *Atlanta**

BY STATUTE, the Composite State Board of Medical Examiners (the Board) is empowered to discipline a licensed physician upon finding that the physician engaged in one of a number of specified activities. Some of these activities relate to a physician's medical practice; for example, the Board may suspend or revoke a physician's license upon a finding that the physician performed an unlawful criminal abortion or violated a law, rule, or regulation relating to the practice of medicine. The Board may also discipline a physician who has been found to have engaged in one of a number of activities totally unrelated to the practice of medicine, such as if the physician has been convicted of a felony or committed a crime involving moral turpitude.[1]

In certain instances, the activities which can provide the basis for Board disciplinary action cannot neatly be classified as related or unrelated to the practice of medicine. One such activity is set forth in O.C.G.A. §43-34-37(a)(7),[2] which authorizes the Board to discipline a physician upon a finding that the physician:

> "(e)ngaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term 'unprofessional conduct' shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice."

The importance of determining whether or not this statutory language involves activities related or unrelated to the practice of medicine is illustrated by a case recently decided by the Georgia Court of Appeals.[3]

Interpretation of "Unprofessional Conduct"

The case involved a proceeding instituted by the Board against a physician alleged to have examined and treated patients while under the influence of alcoholic and controlled substances. Further, it was alleged that the physician had, on the same occasion, driven a vehicle while under the influence of alcohol and drugs, resulting in the deaths of two persons.

Specifically, the evidence adduced showed that the physician had received a

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

telephone call at approximately 3:00 a.m. concerning another physician's patient. In response to the call, in which the physician was informed that the patient had refused to submit to certain diagnostic tests, the physician went to the hospital and, upon arrival, went to the patient's room and examined the patient's chart. The chart indicated that the tests had been performed, so the physician left the hospital to go to a second hospital to see his own patients. En route to the second hospital, the physician was involved in an automobile collision which resulted in the deaths of two persons.

A case is discussed in which a physician was alleged to have examined and treated patients while under the influence of alcoholic and controlled substances.

Subsequently, the physician plead "nolo contendere" to two counts of vehicular homicide in the second degree. The physician also admitted that he had several beers and had taken a methaqualone tablet prior to his visit to the patient. There was also evidence that the physician had taken another prescription drug that evening.

The hearing examiner who first heard the case, as well as the Board, found that the physician had made a medical judgment and had operated a motor vehicle while under the influence of alcohol and controlled substances. As a result of those findings, the Board concluded that the physician's conduct warranted disciplinary action under §43-34-37(a)(7), quoted above, and suspended the physician's license.

The physician appealed the Board's decision to the Superior Court, which found that driving a vehicle under the influence of alcohol and drugs did not come within the ambit of conduct described in the Section relied upon by the Board, because that conduct was "unrelated to the practice of medicine . . . and therefore insufficient as a matter of law to warrant disciplinary action." The Superior Court also reversed the Board's finding that the physician had made a medical judgment while under the influence of alcohol and drugs, based upon its conclusion that the physician's activities did not constitute the making of a medical judgment.

On appeal, the Georgia Court of Appeals affirmed the Superior Court's determination on the first issue that a violation of Section 43-34-37(a)(7) could only be found upon the basis of conduct related to the practice of medicine. As noted by the Court, several of the other grounds for disciplinary action in that Section clearly do not require that the conduct directly relate to the practice of medicine.[4] Unlike these grounds, however, the ground relied upon by the Board dealt with "professionalism, ethics, and standards *of medical practice.*" The reference to "medical practice" persuaded the Court that the physician's activities, while perhaps "unprofessional" or "unethical," in a general context, did not constitute unprofessional or unethical conduct with regard to the practice of medicine, and therefore did not violate §43-34-37(a)(7).

On the second issue, the Court of Appeals disagreed with the Superior Court. As framed by the Court, "(t)he issue is not whether there was sufficient evidence to support a finding that [the physician] was under the influence of alcohol and drugs, but whether the actions he took while under the influence of alcohol and drugs constituted the making of a medical judgment."

In analyzing this issue, the Court first looked to the legal definition of "judgment" — "the formation of an opinion or notion concerning something by exercising the mind upon it." In the Court's view, the physician in fact *had* made a "medical judgment" that the patient did not need further tests:

> "[The physician's] own deposition indicates that he went to the hospital, reviewed the patient's chart, determined that the necessary tests had been made and that the patient was asleep. Based on those observations, [the physician] concluded (made the judgment) that his services were not required by the patient."

The Court also specifically dealt with two contentions raised by the physician. First, the physician argued that he could not be disciplined on the basis of a statutory ground requiring conduct related to the practice of medicine, because he had not in fact practiced medicine — he had not treated the patient. The Court quickly dismissed this argument, however, stating that "(w)hile it may be true that [the physician] did not treat the patient, the decision that no treatment was necessary was made by [the physician] while under the influence of alcohol and drugs. The evidence in this case was that the making of a medical judgment under those circumstances constituted a departure from the minimal standards of acceptable and prevailing medical practice."

Secondly, the physician contended that, even if he had made a medical judgment, that judgment was correct — the patient in fact did not need further testing, and was not harmed by the physician's actions. The Court also rejected this argument, however, noting that the statute under which the Board sought to discipline the physician "specifically negated the requirement that actual harm resulted from the conduct proscribed by . . . [that section]."

Conclusion

In total, the State of Georgia, through the Board, has broad powers to regulate and control the practice of medicine and those who engage in that practice, subject only to the limitations that the measures adopted by the State must be reasonable, necessary, and appropriate in order to accomplish the State's valid objective of protecting the health and welfare of its inhabitants.[6] Because of the importance of this objective, it can be expected that Georgia courts will construe the statutory provisions under which the Board regulates health care practitioners broadly, so as not to unduly restrict the Board in its regulatory activities. The decision by the Court of Appeals in the present case appears to follow this logic; without the benefit of any case law precedent to guide it, the Court selected an expansive definition of the ambiguous term "medical judgment," thereby rendering it applicable in a situation in which the physician's actual conduct involved a judgment *not* to treat a patient.

At the same time, the present case may also be viewed as a warning to the Board that, in selecting the statutory grounds upon which to discipline a physician, the Board should be sure that the particular ground selected accurately reflects the conduct for which the Board seeks to exercise its disciplinary authority. A failure to do so by the Board — such as in the present case, with respect to the Board's unsuccessful attempt to discipline the physician on the grounds of engaging in "unprofessional" activities stemming from his driving a vehicle under the influence of alcohol and drugs — could result in the Board's inability to discipline the physician at all.

[Editorial Note: Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power either to affirm or to reverse the decision of the Georgia Court of Appeals, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article, although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. In the event that the case discussed in this article is appealed and subsequently reversed by the Georgia Supreme Court, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.*]*

Notes

1. O.C.G.A. Section 43-34-37(a).

2. Effective as of November 1, 1982, the Georgia Code Annotated (1933) was repealed and replaced by the Official Code of Georgia Annotated (1981), a recodification of the Georgia statutory laws. In particular, former Ga. Code Ann. §84-916 was recodified as O.C.G.A. §43-34-37.

3. *Composite State Board of Medical Examiners v. Hertell*, ___ Ga. App. ___ (September 15, 1982).

4. For example, §43-34-37(a)(3), dealing with the conviction of a felony; §43-34-37(a)(4), dealing with the commission of a crime involving moral turpitude; and §43-34-37(a)(11), dealing with the commission of an act indicative of bad moral character or untrustworthiness.

5. *Composite State Board of Medical Examiners v. Hertell, supra*, ___ Ga. App. at ___.

6. See, e.g., *Geiger v. Jenkins*, 316 F.Supp. 370 (N.D.Ga. 1970), aff'd, 401 U.S. 985 (1971).

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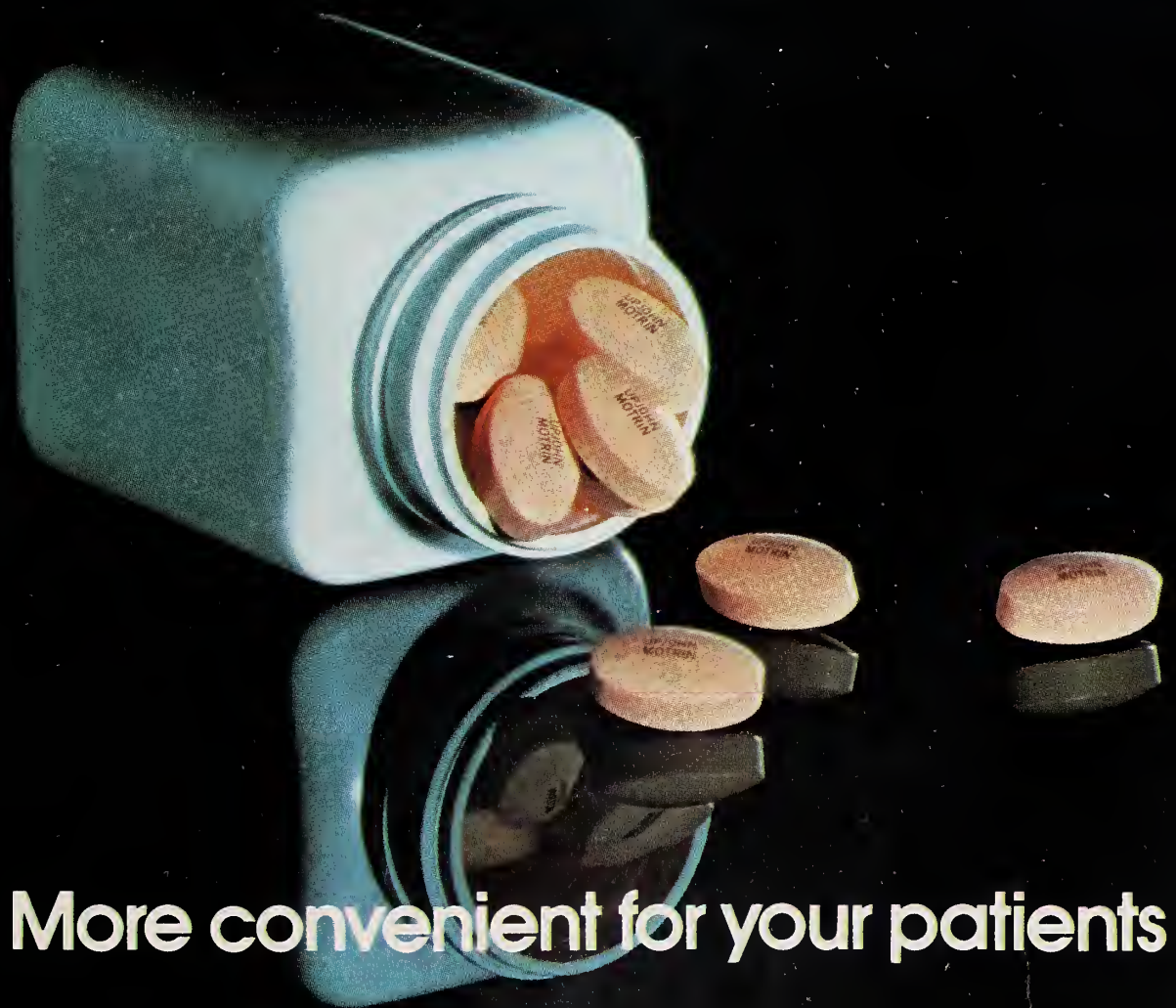
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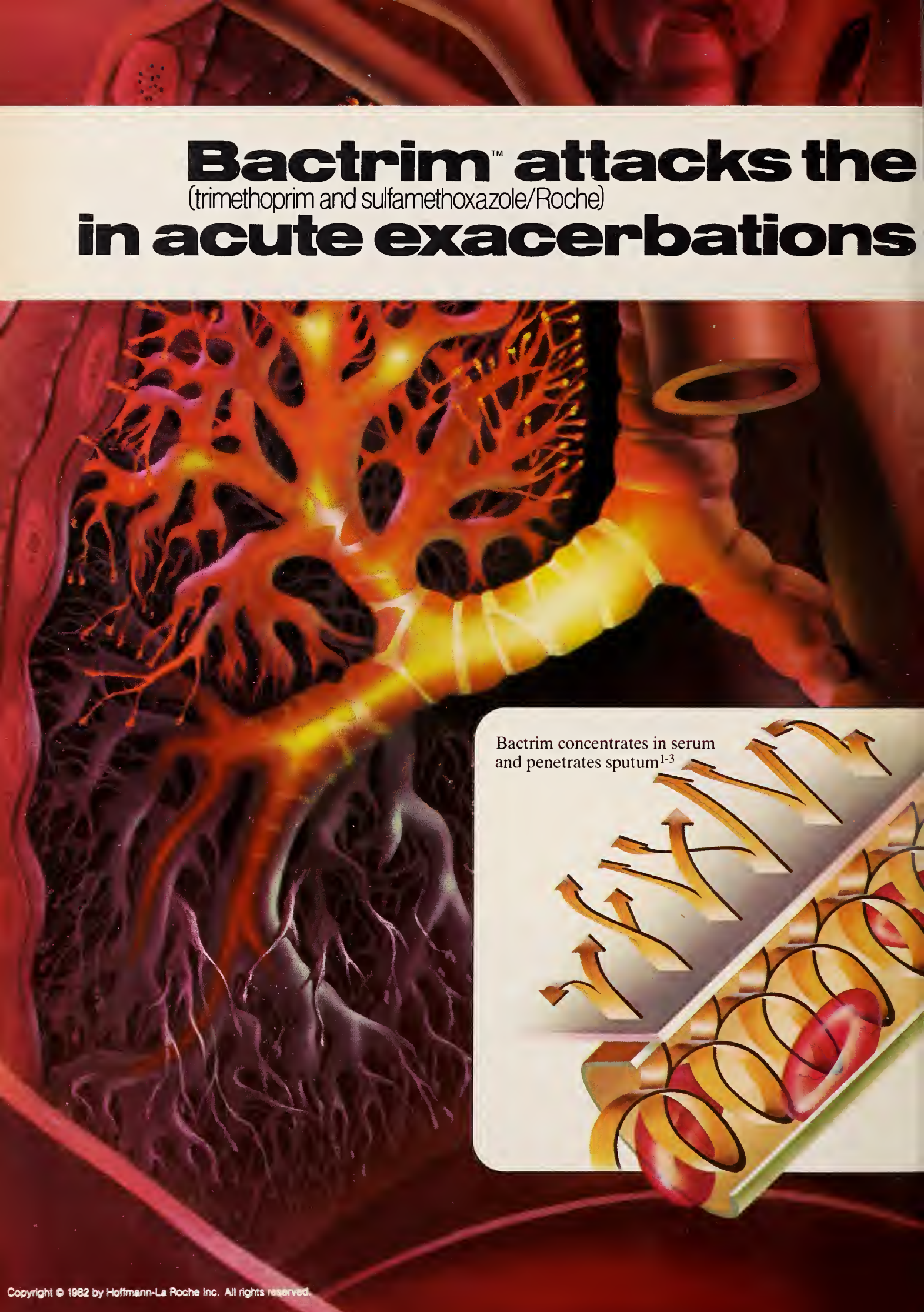
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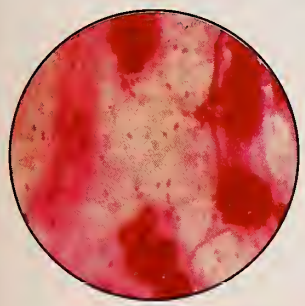
major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

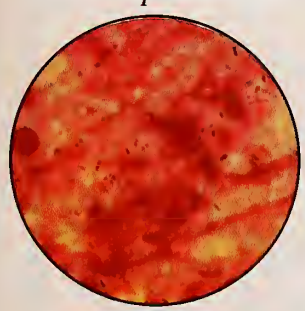
In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

attacks *H. influenzae*—even ampicillin-resistant strains



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Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection 6*(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

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*Due to susceptible organisms. **Please see next page for summary of product information.**

Bactrim™

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

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Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

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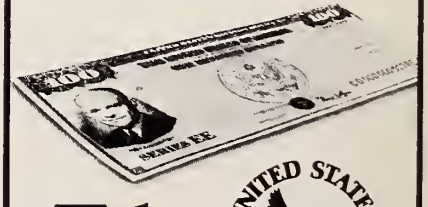
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heart page
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Doppler Ultrasound in the Evaluation of Cardiovascular Disease

DON P. GIDDENS, PH.D., *Atlanta**

DOPPLER ULTRASOUND instruments offer a safe, noninvasive, and reasonably accurate method for hemodynamic study of isolated blood vessels. The technique is based upon the familiar Doppler effect that waves which are reflected from a moving target experience a change in frequency which is proportional to the velocity of the target. In the case of diagnostic ultrasound, these incident waves are mechanical waves with frequencies typically ranging from 2 to 10 million cycles per second (MegaHertz, MHz) for available commercial instruments. The term "ultrasound" is used since these frequencies are well above the hearing range of human ears. The equation governing this phenomenon is, to first order effects,

$$f_D = \frac{2\,u\cos\theta}{c} f_o$$

where f_o is the transmitted frequency, u is the speed of the targets, cos θ is the cosine of the angle between the ultrasound beam and the velocity vector of the target, c is the speed of sound in the medium, and f_D is the Doppler frequency — that is, the difference between the frequencies of the reflected and incident waves. The targets in the case of blood flow are the blood cells. For an example application, consider the blood velocity in the common carotid artery. Diastolic values might be on the order of 5 cm/sec, while peak systolic values might be approximately 80 cm/sec. With a 5 MHz Doppler system, an angle of 45° between the beam and blood velocity vector and using a value of c = 1500 meters/sec for the speed of sound in tissue, the resulting Doppler frequencies are in the range of approximately 200-3800 Hz, values within the hearing range. Consequently, the Doppler frequencies — as opposed to the ultrasound frequencies — may be "listened to" with the ear when blood velocity measurements are performed.

The first biomedical Doppler devices in the late 1950s were transit time instruments but did not prove useful since they required transducers to be on both sides of a vessel. In the early 1960s, continuous wave Doppler instruments were developed, and these are still quite popular in view of their inexpensive cost and ease of use. Continuous wave systems employ both transmitting and receiving piezoelectric crystals on the same transducer face, and both crystals are continuously active. Any moving target within the intersection of the acoustic windows of these transducers

Dr. Giddens is Regents' Professor of Aerospace Engineering, Georgia Institute of Technology, Atlanta, GA 30332. Send reprint requests to him. He has served on the Research Committee of the Georgia Affiliate of the American Heart Association and was Chairman in 1980-81. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

contributes to the Doppler signal. Thus, the Doppler "frequency" which is measured is by no means a single frequency but a combination of many frequency components since the velocity varies over the lumen of a vessel. (Actually, it is a fundamental limitation of any Doppler system, even under the most ideal conditions, that the signal does not contain a single frequency. If velocity variations are also present, this situation is aggravated.)

Two significant advances were made by electrical engineers between the mid-1960s and early 1970s. First, F. D. McLeod[1] (1967) developed a method to distinguish between forward and reverse velocities — hence, the term "bidirectional Doppler." Shortly thereafter, several investigators, among them McLeod, P. A. Peronneau, D. W. Baker, and J. D. Meindl developed pulsed Doppler instruments which allowed the selection of information from a desired range along the beam axis. Pulsed Doppler instruments employ a single piezoelectric crystal for both transmitting and receiving. The crystal is stimulated briefly to create a "pulse" of ultrasound and then allowed to act as a receiver until it is again activated for the next pulse. Using echo principles the received signal may be range-gated to select Doppler frequencies arising from a desired location within the vessel. However, the sampled "point" is actually a small volume whose dimensions depend upon factors such as crystal size, transmission frequency, length of the pulse, and length of sampling time. A well-designed 5 MHz Doppler system will have a sample volume on the order of 2 mm^3, for example, thus allowing selective interrogation over the lumen of larger arteries.

Doppler ultrasound instruments can play a vital role in diagnostic medicine since they provide information on vessel function which is unavailable with noninvasive imaging systems.

Doppler devices have understandably found increasing use since their introduction to biomedical applications. The power levels required are entirely safe for use in the study of hemodynamics (less than 50 milliwatts/cm^2). For deeper vessels, lower ultrasonic frequencies are required, such as 2 MHz, since wave scattering increases as the fourth power of frequency. With such frequencies the ascending aorta, aortic arch, and deep-lying peripheral vessels can be explored if a good acoustic path (no intervening gas space or bone) is available. For more superficial peripheral vessels and the carotid arteries, systems employing 5-10 MHz may be used.

It is emphasized that Doppler devices are velocimeters, not flowmeters. To measure the blood flow rate in a vessel requires a determination of either the velocity profile across the lumen or the spacially averaged velocity and a measurement of the vessel area itself, since flow is the product of mean velocity and area. Thus, to be employed as a flowmeter, a Doppler instrument must be (i) capable of measurement of the mean velocity and (ii) employed in conjunction with some form of wall imaging technique. Although several investigators have reported recently on using Doppler instruments as flowmeters, the accuracy of such measurements is still a matter of debate within the research community. Any attempts to employ these instruments in a flowmeter mode should include consultation with a biomedical engineer, any claims made by device manufacturers notwithstanding.

Despite uncertainties associated with their use as flowmeters, Doppler ultrasound instruments can play a vital role in diagnostic medicine inasmuch as they provide information on vessel function which is unavailable with noninvasive imaging systems. There are many instances in which the blood velocity waveform pattern, for example, is extremely useful in a diagnostic mode. Insofar as diagnostic uses are concerned, the role of Doppler ultrasound continues to grow. Vascular laboratories routinely employ very inexpensive continuous wave Doppler systems in quite reliable analysis of venous maladies. A great deal of valuable screening

information may be obtained in carotid arterial disease with such simple systems; and by the addition of Doppler measurements to ultrasonic imaging systems, both functional and anatomic data may be obtained. Spectral analysis of the Doppler signal can add further information in the diagnosis of atherosclerotic plaque in the region of carotid bifurcation, although it is the author's opinion that much more research is necessary in this area. Recently, pattern recognition of velocity waveforms in the common carotid arteries of neonates has proven to be a sensitive and specific indicator of patent ductus arteriosus (Wilcox, et al[2]). Relative changes, if not absolute values, for cardiac output in adults now appear to be quite feasible. On the other hand, Doppler methods cannot be employed very well for regional blood flow studies inasmuch as the technique is best suited for examination of isolated vessel segments.

In summary, Doppler ultrasound has proven to be a safe, noninvasive, and inexpensive method for obtaining circulatory information in a variety of cardiovascular and cerebrovascular problems. It can provide valuable hemodynamic data which complements information available from imaging systems. Since there are subtle fluid dynamic and instrumentation factors of which the user should be aware, new applications are best approached through consultation with a knowledgeable biomedical engineer. Once experience is gained with a system, however, the amount of additional information available is indeed surprising.

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1. McLeod FD. A directional Doppler flowmeter, Dig. 7th Int. Conf. Med. Biol. Engng, 213, 1967.
2. Wilcox WD, Carrigan TA, Dooley KJ, et al. Range-gated pulse Doppler ultrasonographic evaluation of carotid arterial blood flow in small preterm infants with patent ductus arteriosus. To appear in J Pediat, 1982.

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president's letter



The New Leadership

At the MAG Leadership Conference last November, we heard from nationally recognized authorities that the practice of medicine is in a period of true revolution. The medical world around us is exploding. We learned, among other things, that:

1. The "physician glut," the tremendous increase in the number of physicians being produced, will create an environment in which a young physician will not often be able to enter a private "fee-for-service" practice, afford professional liability insurance premiums, or obtain hospital privileges;
2. Physician and hospital incomes will be limited by what government and business, the primary payors, are willing to disburse for medical services;
3. Hospitals are entering competitively into the private practice of medicine and will play an increasingly dominant role in the professional lives of physicians;
4. Hospital privileges will be scrutinized much more carefully, year by year, and credentials, once obtained, might well be challenged if the standards of practice are not well documented and scrupulously maintained;
5. Business is insisting upon changes in practice patterns which will reduce health insurance costs and is willing to negotiate these changes — preferred provider groups are appearing as a result of the negotiations already in process;
6. With the phasing out of PSRO and the appearance of UQCPRO, increasing opportunities will be afforded physicians in organized medicine to direct the review processes, but with these opportunities will come greater responsibilities.

Traditionally, in America, leaders have emerged to take charge when significant crises have arisen. Such a crisis is now upon us in medicine, and a very special kind of leadership will be required to deal with it. The brightest and best among us — those with the motivation to learn about the problems and with the skill, tact, and tenacity to negotiate effectively with hospital administrators, business leaders and politicians — must assume top roles of responsibility. In effect, we must have a strong union with tough, bright, skillful leaders.

We are not advocating an exercise in self-service or special interest. The American public needs well motivated physicians to remain in charge of the environment in which medical services are rendered.

In order to accomplish our objectives, we should offer more forums for diverse leadership groups, such as we had at Callaway Gardens. Our leaders must share their knowledge and combine their efforts in order to preserve for the public the advantages of the independent, free enterprise practice of medicine. No other system can offer the quality of care they have learned to expect.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

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PERSONALS

Second District

Mark W. Fowler, M.D., of Albany, spent the month of September in Africa, where he supervised clinics and worked at Malamulo Hospital.

Third District

Dee B. Russell, M.D., director of the Medical Center's family practice clinic in Columbus, was named the first Family Practice Educator of the Year by the Georgia Academy of Family Physicians in Atlanta. Dr. Russell oversees training of 36 residents who plan to enter family practice.

Fourth District

Clyde B. Rountree, M.D., of Decatur, was appointed director of mental health services for DeKalb General Hospital. Dr. Rountree has been involved with the Mental Health Unit at DeKalb General for 15 yars. He was the first Chief of Psychiatry at the hospital and also served as chief of staff.

Fifth District

Leila Denmark, M.D., an Atlanta pediatrician, was commended recently by an article in a local newspaper for her many years of service to the Atlanta area. Dr. Denmark, who is now age 84, was recently named an honorary board member of Henrietta Egleston Hospital for Children. In her career, spanning 54 years, she is most noted for her pioneering efforts in developing vaccines for whooping cough and measles.

John T. Godwin, M.D., recently completed an around-the-world tour visiting various health facilities in Bangkok, Hong Kong, and Tokyo. During the trip, Dr. Godwin participated in a course in hepatic pathology at the Armed Forces Institute of Pathology, Washington, D.C. He returned to Saudi Arabia and is preparing seminars on tumor registries, histotechnology, blood banking, and electron microscopy for Mideastern medical personnel and physicians in the capital city of Riyadh, Kingdom of Saudi Arabia. He serves there as chairman of the Department of Pathology and Laboratory Medicine at the King Faisal Specialist Hospital and Research Center and Cancer Treatment Center.

Atlanta general surgeon, **A. Hamblin Letton, M.D.,** has been chosen to deliver the Roswell Park Memorial Lecture in February, 1983. This lecture is customarily given at the annual meeting at the Roswell Park Cancer Institute in Buffalo, New York.

Sixth District

William M. McClellan, M.D., of LaGrange, traveled to Tel Aviv, Israel, in November to present a paper on hypertension written by him and **Joe A. Wilber, M.D.,** of Atlanta. The paper was presented at the International Symposium on Hypertension Control. Dr. McClellan, a nephrologist, has given much of his free time during the past 6 years to the study of hypertension. He started the Community Hypertension Control Program in LaGrange in 1976.

Gordon W. Jackson, M.D., of Macon, spent the month of October as a volunteer in the Department of Obstetrics and Gynecology at the Lyndon B. Johnson Tropical Medical Center in Pago Pago, American Samoa.

Seventh District

Rome physician, **Ernest W. Culbreth, M.D.,** recently received the 1982-83 regional Physician's Physician Award. Dr. Culbreth, a family practitioner, was selected to receive this award by his fellow Medical College of Georgia alumni in the Rome area. The award was presented last October at the MCG School of Medicine Alumni Association regional dinner meeting in Rome.

Hamilton S. Dixon, M.D., was one of 27 physicians honored by the American Academy of Otolaryngology — Head and Neck Surgery for his contribution to otolaryngological medical education. The awards were presented at the annual meeting of the Academy October 17-21 in Washington, D.C.

Eighth District

Donald A. Zorn, M.D., of Blackshear, has been named a Fellow of the American Academy of Family Physicians.

Ninth District

Carl D. McCurdy, M.D., Jasper physician, has been named a Diplomate of the American Board of Family Practice.

SOCIETIES

The Georgia Medical Society held its annual membership oyster roast on September 14. This annual event is a Membership Rush Party. Special guests were resident physicians from the Memorial Medical Center and new physicians in the community. The oyster roast was held at the beautiful Old Fort Jackson on the Savannah River. There were 165 in attendance.

The Answers — Public Opinion Survey

(Continued from page 16)

1. Two out of three Georgians consider costs to be the number one problem facing health care and medicine in Georgia today. In an open-ended question, to which the respondent could have answered whatever came to mind, cost-related concerns were given in 63% of the answers; 12% responded with quality-related answers; 8% talked about access; and the remaining 17% listed other concerns.
2. In a related question, we asked, "Do you think we spend too much money, too little, or about the right amount on health care?" Fifty percent said not enough, 16% said too much, and 32% said about right. Two and one half percent said they weren't sure.
3. As to whether there are too few doctors, too many, or not enough, 49% think the number of doctors is about right; 40% say not enough; 8% say too many; and 3% are not sure.
4. Regarding patient satisfaction, a series of questions were posed. We are tremendously pleased with the answers. To the question of how satisfied the public is with their most recent visit to a medical doctor, 94% were satisfied overall. Ninety-four percent were satisfied with the medical care they received; and 92% with the way the doctor's staff treated them.
5. With respect to the amount of time the public had to wait in the office, 49% were very satisfied, 33% were fairly satisfied, 11% not too satisfied, 7% not at all satisfied, and 1% not sure.
6. As to what is important in their choosing a physician, 91% think the recommendations of friends is important; 73% think fees are important; 99% say the doctor's qualifications and training is important; 44% say advertising (such as in a telephone directory or newspaper) is important; and 93% say the length of time to get an appointment is important.
7. As to how important are the fees in selecting a doctor, 73% say important; 16% say not very important; and 11% not at all important.
8. Do doctors take a genuine interest in their patients? Sixty-eight percent say we do. However, nearly one third (31%) say we do not.
9. Do doctors act like they are better than other people? Sixty-four percent say no; one-third say we do (34%).
10. Are poor people able to get needed medical care? Fifty-seven percent say they are not; 40% say they are; and 3% aren't sure.
11. Are people beginning to lose faith in doctors? Sixty-two percent say they are; 37% say they aren't; 1% are not sure.
12. Do doctors explain things well to their patients? Fifty-three percent say yes; 47% say no.
13. Do you have enough money or health insurance to pay for the usual medical costs of your family? Seventy-three percent say yes; 27% are not confident.
14. Are you confident that you have enough money or insurance to pay for a major illness? Sixty-one percent say yes; 40% say no.
15. Which persons or what groups deserve a *lot* of responsibility for the rising costs of medical care? In order of who is "to blame," the public listed: hospitals, 53%; doctors, 50%; insurance companies, 48%; drug companies, 47%; patients who seek unnecessary care, 45%; people who don't pay enough attention to preventive health care or who have unhealthy personal habits, 44%; government agencies that set and enforce health care standards, 43%; and tied at 36% are organized groups such as the AMA and unions. It is clear that the public believes there is a cost problem but is confused and fragmented in terms of who is primarily responsible. This kind of situation causes a potential for "scapegoating" especially if the cost issue becomes more volatile politically.

Sixty-eight percent of our patients believe we take a genuine interest in them.

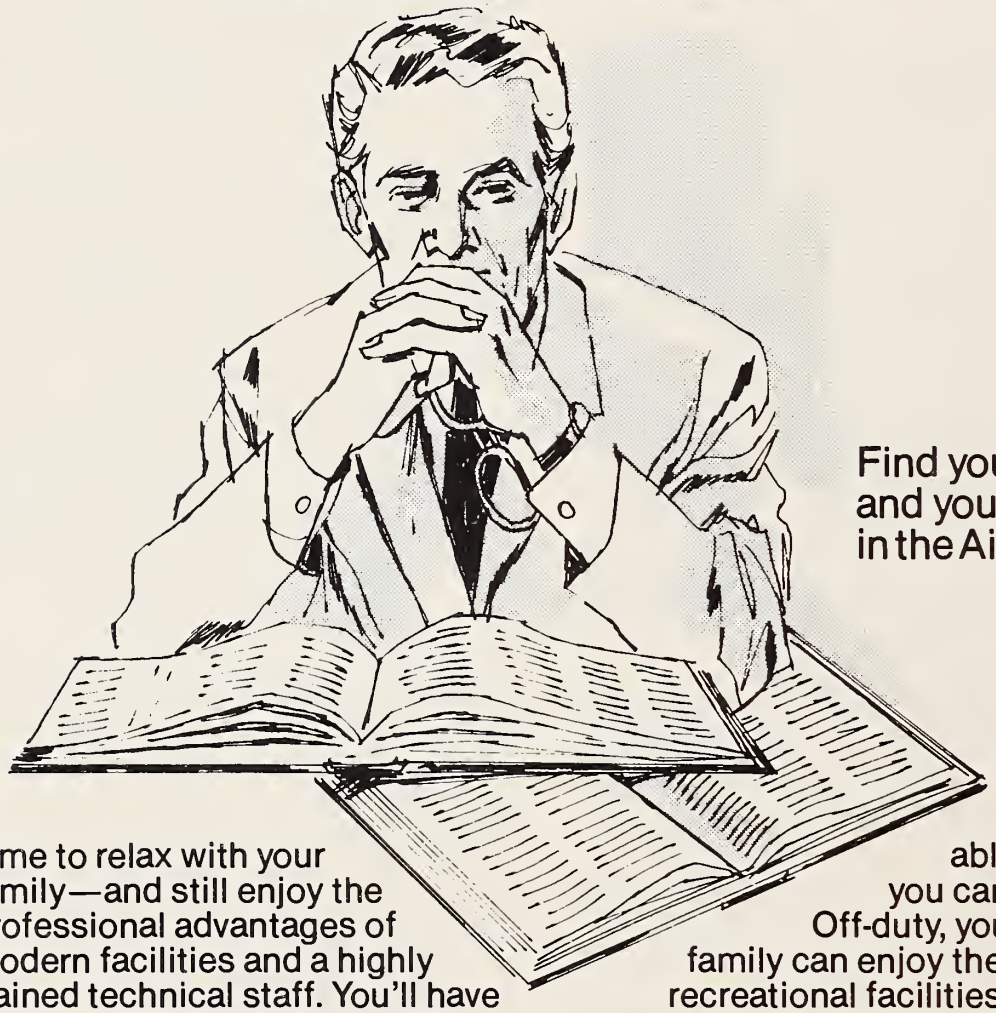
16. Is it ethical for doctors to advertise? Fifty-six and a half percent say yes; 42.7% say no.
17. Do you believe good doctors will advertise? Fifty-four percent say no; 45% disagree.
18. Are people usually justified in suing physicians? Forty-three percent say yes; 46% say "people who sue doctors are just looking for an easy way to make money"; 11% are not sure.
19. Are doctor's fees usually reasonable? Sixty percent say no; 40% think they are.
20. Rather than having a personal physician, would you object to being treated by a group of doctors such as in a clinic? Forty percent approved; 59% disapproved.

Next month, we'll talk about the public's number one concern — COSTS — and some suggestions on what we, as physicians, and others can do.

Following this series, reprints of the survey results (all 35 pages) may be obtained by contacting: Mr. Ken Williams, Medical Association of Georgia, 938 Peachtree Street, NE, Atlanta, GA 30309.

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AIR FORCE

Committee Activities . . .

Highlights of the November 1982 Meeting of the MAG Executive Committee

The Executive Committee conducted the following business at its November, 1982, meeting:

* Agreed to recommend to the January meeting of the MAG Board of Directors that MAG add to its House of Delegates one delegate and one alternate from each state specialty society recognized by the MAG Interspecialty Council. The matter was also referred to the Constitution and Bylaws Committee.
* Will seek the establishment of a common examination for all who seek Physician Assistant (PA) certification. This would require legislation by the Georgia General Assembly.
* Heard a report from the Public Relations (PR) Committee that a proposal for an MAG PR Department is being developed for submission to the April MAG House of Delegates.
* Directed the Constitution and Bylaws Committee to draft language to create a Hospital Medical Staff Section to the House of Delegates.
* Appointed Kenneth L. Goldman, M.D., Columbus, as chairman of the Membership Insurance Committee, replacing W. Perrin Nicolson, M.D., deceased.
* Empowered MAG President, Charles D. Hollis, Jr., to appoint four MAG members to a Joint Committee on Aging in cooperation with the Georgia Academy of Family Physicians.
* Agreed to notify all MAG delegates and alternates that the report of the Ad Hoc Committee on Podiatric Study represents nothing more than a summary of the findings of the committee; that the findings are not MAG policy; and that the report is for internal use only.
* Heard a report that the MAG is entitled to a sixth AMA delegate and alternate and will elect same in April at the MAG House of Delegates.
* Heard a report that MAG Mutual has revenues of some six million dollars and that MAG Mutual may be faced with an increase in premiums in early 1983.
* Supported proposed revisions of the rules and regulations pertaining to eye banks in Georgia which implements a law passed early this year. The 1982 Georgia General Assembly revised the law relating to eye banks which limits eye banks to those facilities ''operated by or under a medical school in conjunction with the department or school of ophthalmology of such school.'' The two schools that have such facilities are Emory and MCG.
* Heard a report of the MAG Building and Land Committee which recommends that the MAG headquarters building be expanded by some 6,000 sq. ft. to accommodate the growth of MAG Mutual.

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CPC Peachtree-Parkwood Hospital is a private, comprehensive mental health center designed and staffed to meet the individual needs of patients through the following specialized programs:

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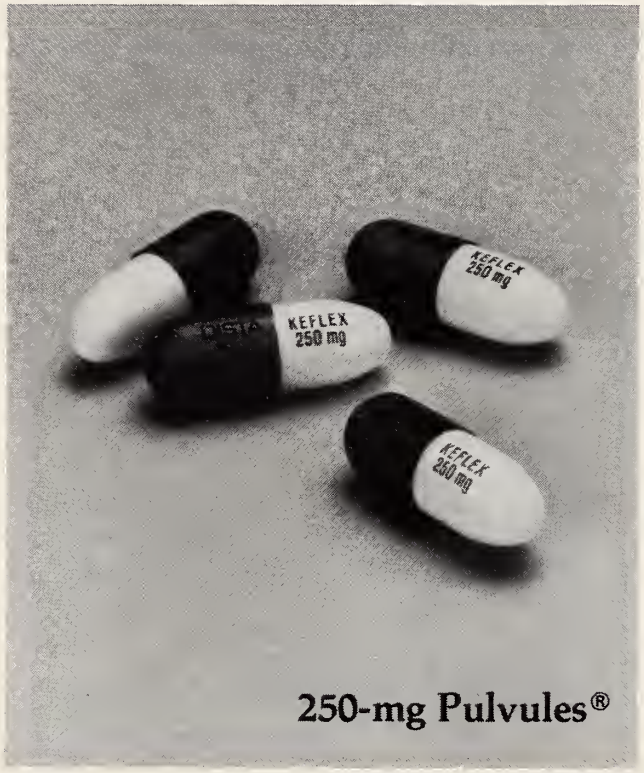
Additional programs and services include a Day Hospital Program and an Occupational Mental Health Services Department.

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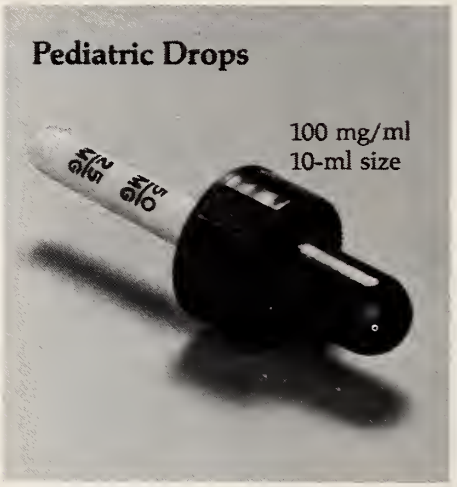
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This procedure is performed in one office visit. The visit usually takes 1½ hours to 2 hours. It includes: history, physical examination, pulmonary function tests, EKG, blood test, urinalysis, the injection, behavioral modification tips, and a smoker's diet that I conceived. I have noticed that for optimal results, the patient must be highly motivated to want to stop smoking.

The usual and customary fee I charge patients for the aforementioned is $385. Their sincere willingness to pay this amount adds to their commitment.

It would be impossible for me, using this form, to go into great detail concerning this comprehensive method. It is for that reason that I, through *Consultants in Medical Education*, have agreed to lecture to interested physicians who desire to use it.

It disturbed me greatly that as a result of the positive coverage in the lay press, including glowing testimonials from successful patients, a few, solely profit-oriented individuals, have made great personal fortunes by offering their own "lay" brand of this procedure. I feel a responsibility to the millions of cigarette smokers who desperately want to quit. I also feel a responsibility to share with my colleagues the details of this procedure.

If you desire further information concerning this program, please direct all correspondence to Consultants in Medical Education at:

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Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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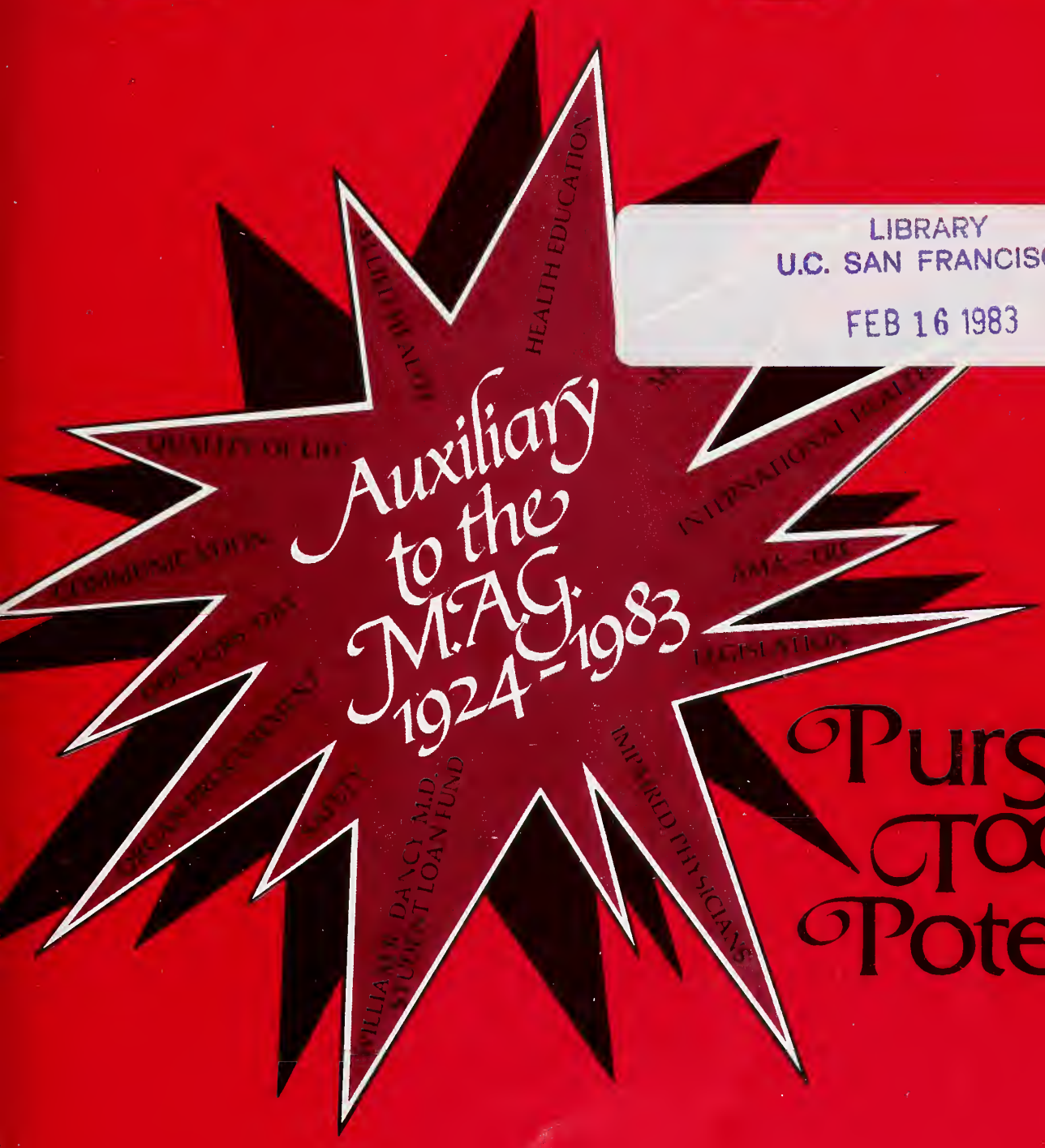
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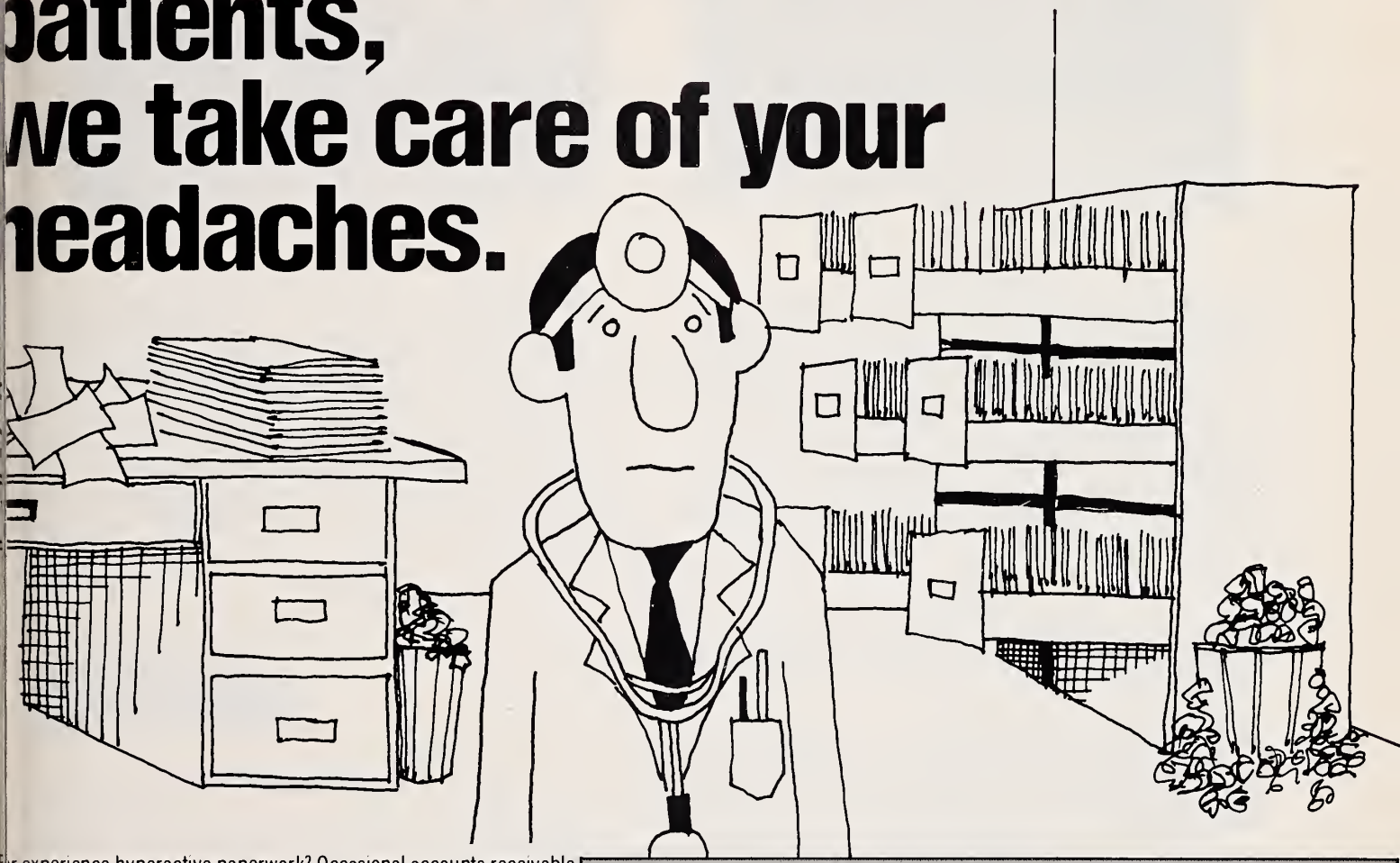
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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

This month's cover, designed by Mrs. Dent W. (Ann) Purcell, of Savannah, highlights the variety of projects in which the Auxiliary to the MAG is involved. The diversity, depth, and dedication of Auxiliary members' involvement in the lives of others is greater than perhaps even many physicians and their spouses may be aware. This special issue — the first of its kind in the history of this Auxiliary — focuses on some of their accomplishments and ongoing projects. Special thanks go to Mrs. Brit B. (Evelyn Ward) Gay, Jr., who served as guest editor of this issue.

Artwork by Richard Lyons, of Richard Heiman Advertising, Inc., Atlanta.

Incidental Intelligence . . .

Live It Up — Naturally

About 4 years ago, the Richmond County Board of Education requested that the Auxiliary to the Richmond County Medical Society produce and perform a puppet show designed for students in grades 8 and 9. The theme was to be based upon improving one's self-image and on the dangers of drug and alcohol abuse. The success of a previous puppet show, "Drugs Are A Drag," as a teaching tool had prompted this action. That show, geared toward a younger audience, had originated about 10 years ago with the Medical Association of Atlanta Auxiliary and had been copyrighted by that group. It is still available to interested auxiliaries through the AMA Auxiliary's Project Bank, which lists many programs for nationwide use.

In order to begin the new show, the Richmond County Board of Health secured funds through grants to cover production and equipment costs, as well as for pre- and post-show testing of the students. An experienced producer of such shows was then engaged to write the script; to provide original music, an audio tape, puppets and props; and to teach the choreography to the auxiliary puppeteers. She met with representatives of the Board of Education, Board of Health, Augusta Area Mental Health Center, Medical Society and Auxiliary to discuss the philosophy of the show and to secure advice. From this came the lively rock-musical "Live It Up — Naturally." Through music and humor, the show highlights coping with peer pressure, making decisions, solving problems, finding alternatives to alcohol and drug abuse, and accepting one's self.

The 23 auxiliary puppeteers rehearsed for several months, and in the following 3 years of performances the show reached approximately 12,000 students. It has been well received by both the students and faculties. Testing of the students, as well as classroom discussions, have determined that the purposes of the production were accomplished.

In addition to the performances in the schools, the puppeteers have also presented the show at a Summer Board meeting of the AMAG in Atlanta, a State Mental Health Association meeting in Savannah, a high school in Dublin, and a District Board of Health meeting in Augusta.

Several other counties across the state are actively participating in showing the puppet show to the students in their areas, in conjunction with their own projects dealing with drug and alcohol abuse.

(Reported by Mrs. Mark [Julie] Brown, of Augusta, who is a past-president of the Richmond County Medical Auxiliary, and a former editor of Pulse Line.)



"Live It Up — Naturally" has been shown at several county auxiliary meetings, including the Tift County Auxiliary's community drug program.

The Georgia Poison Control Center Needs Your Support

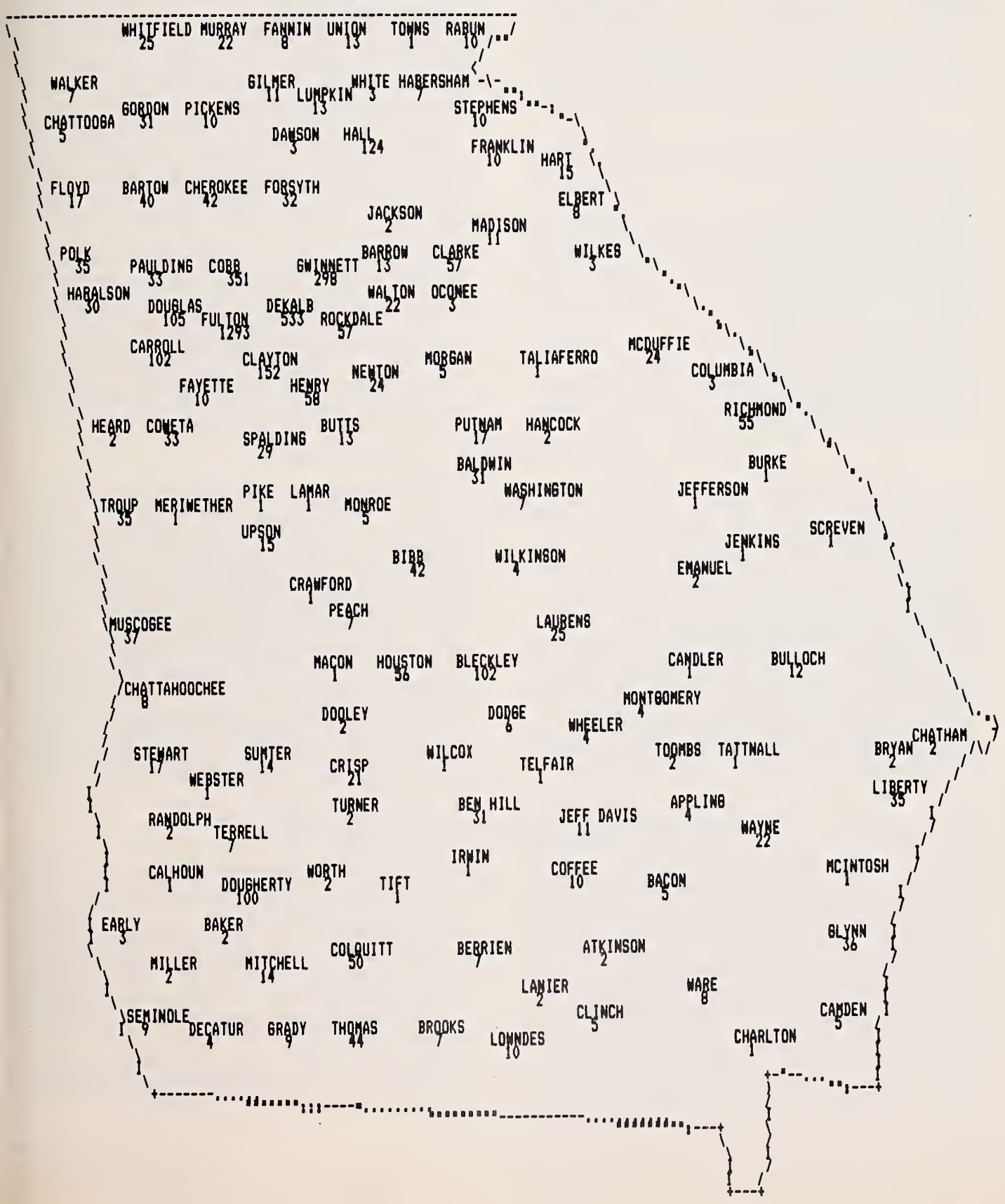
The medical profession of the state has a great stake in the Georgia Poison Control Center. We are in very real danger of losing this resource, primarily due to cutbacks in federal funding. We ask that every Georgia physician support us by enlisting the support of his or her local legislator at the upcoming legislative session. We barely missed adequate support in last year's session

The Georgia Poison Control Center has served the state well. As of November, 1982, a total of 27,946 calls were received from the general public from 156 of the state's 159 counties. This is in addition to the number of calls received from medical providers as shown in the attached map. We also received 728 calls from other states and seven from foreign countries.

Please contact your legislator and let him or her know of the benefits to the public of our activities.

(Reported by Albert P. Rauger, M.D., Director, Georgia Poison Control Center.)

GEORGIA POISON CONTROL CENTER
4703 CALLS FROM THE MEDICAL CARE PROVIDERS OF 130 OF GEORGIA'S 159 COUNTIES
1982 YEAR TO DATE — NOVEMBER



Who Heals the Healer?

One of the measures of our society is the degree of health care available, and the prime resource of this care is dedicated physicians. When there is illness, injury, or pain there is a physician ready to offer healing skills. But who heals the healer? Who is ready to help mend a broken practice and a crippled human being who has become impaired as a result of alcohol and/or drug addiction or emotional disturbances? The physician is at high risk of these impairments. When this occurs, they are classified as "Impaired Physicians."

In 1975, the MAG initiated the Impaired Physicians Program. A four-phased program of identification, motivation, rehabilitation, and re-entry was implemented. More experience has been gained in treating impaired physicians in the Georgia Program than anywhere in the United States. This Impaired Physicians Program has become a model for similar programs both in the United States and abroad. The program is dedicated to the concept of caring for their sick and ill colleagues, while exercising quality control of medicine for the citizens of this state.

The Auxiliary to the MAG has been actively involved in this project. There have been programs and workshops on the Impaired Physicians Program, Drug Education, How to Cope with the Stress and Strains of the Professional Family, Financial Planning, and Community Resources.

The Auxiliary has been represented at national programs sponsored by the American Medical Association and numerous workshops. In October, 1982, the Georgia program was presented in Portland, Oregon, for the Impaired Physicians Conference, the Northeast Conference on Addictions held in Wakefield, Massachusetts, and the National Symposium on Psychiatry/Chemical Dependency in Atlanta.

Emotional support for the spouse and family of the impaired physician has been tremendously important, and this support has been provided by Auxiliary members in the physician's home community. Spouses have been included in Auxiliary projects and social functions, and have been provided support and friendship.

During the presidency of Mrs. Milton B. (Ann) Satcher, Jr., of Atlanta, the Doctor's Family Alcohol and Drug Assessment Kit was prepared and distributed to Auxiliary members throughout the state to allow physicians, their spouses, and children to carefully assess their intake of mood-changing drugs. These kits have been requested by auxiliaries throughout the United States.

County auxiliaries have also provided financial support and numerous types of equipment and appliances to the residential treatment facilities (half-way houses). Linens, color televisions, clothes, washers and dryers, stereos, electric coffee pots, and toasters are but a few of the items donated.

Many physicians who would have been unable to return to practice and would have been lost forever to medicine are now successfully, soberly, and constructively returning to their communities to practice medicine.

(Reported by Mrs. J. Luther [Margaret] Clements, Jr., a member of the Auxiliary to the Medical Association of Atlanta and the state's Medical Auxiliary Consultant to the Impaired Physicians Program of MAG.)

1983 Atlanta Heart Ball Set for March

The second annual Atlanta Heart Ball will be held on Saturday, March 26, 1983, at Colony Square. Special honoree will be R. Bruce Logue, M.D., founding president of the Georgia Heart Association (GHA).

Proceeds from the ball will go to the American Heart Association, Georgia affiliate, whose activities focus on three major areas: research, community service, and public and professional education. The Georgia affiliate was organized in November, 1948, by approximately 60 Georgia physicians. The GHA is one of 55 AHA affiliates and is currently headed by Lois T. Ellison, M.D.

Dr. Logue, a graduate of Emory College and Emory School of Medicine, joined the faculty of the Medical School in 1945 and became head of the Internal Medicine Division of Emory University Clinic at its founding in 1953. He served as chief of medical services at Emory University Hospital from 1957 to 1980, when he was appointed director of the Carlyle Fraser Heart Center at Crawford W. Long Hospital, a position he still holds. In 1978 the R. Bruce Logue Chair of Cardiology was established by the Emory University Board of Trustees.

The Georgia affiliate, AHA, has allocated a record total of $609,304 for heart research this year, reflecting a 92% increase in its support. This total includes $290,142 for the Georgia affiliate's research program and $319,162 for AHA's national research program. Research projects and awards of grants-in-aid are funded at Emory University, Georgia Tech, and the Medical College of Georgia.

Physician Involvement Program (PIP)

To ensure the success of its legislative program, *MAG needs your active involvement.* MAG is, for the third year, sponsoring the Physician Involvement Program (PIP). The goal of this program is to have at least ten physicians per day attend a session of the General Assembly. You must be there to tell your legislators how their actions will affect you, your practice, and your patients.

Each session begins at 8:30 a.m. with coffee and a briefing at the Stadium Hotel which is located at 450 Capitol Avenue, 2 blocks from the Capitol. The briefing session includes an explanation of how legislation is introduced, considered in committee, and voted on by each house. The briefing also includes a summary of legislation that MAG is tracking and an explanation of any bills that will be considered that day.

At approximately 9:15, the participants go to the Capitol by shuttle bus so each physician will have the opportunity to meet his legislators. The rest of the day is free to observe the Senate and House in session or attend any committee meetings or hearings of interest. MAG staff is available to assist you.

To get involved in this program, please call MAG at 876-7535 or toll free 1/800-282-0224. Your help is needed! Please volunteer.

Allied Health Careers Clubs

A student from Benjamin E. Mays High School in Atlanta, praising the work of her Allied Health Careers Club, said: "My club helps me in many ways. I plan to become a pharmacist, and the club gives me the experience to make decisions about my future plans and provides me with hands-on experience." Her comment inspires me to find more avenues to help these aspiring young adults to find ways to reach satisfying careers in the health fields.

This young lady and the other AHCC Board members from throughout the state met with me on October 30 in Macon. Though I expected to be the provider, giving them each thick packets of information to carry back to all their club members, they were also providers. Each student filled out a questionnaire about their club activities and gave suggestions for some useful programs, projects, and board meetings. Their comments have shed some new light on a job I now realize is one of the most needed of those provided by the Medical Auxiliary.

These "kids" are eager; they know where they are going, be it into nursing, physical therapy, nutrition, or any of the other health-related fields. They are looking to us to help them find the way, and we can help in many ways: financial aid and advice, information on careers, or the actual experience which generates their enthusiasm. This project deserves our highest priority.

One of their main desires is hands-on experience. This is a real problem area, since many hospitals do not allow their aid through significant volunteer work. These students are serious about health careers, and they *are* the cream of the crop. They deserve an opportunity to discover the realities of health work through something more meaningful than pushing a juice cart in a hospital or, in some cases, just "having a club." These are the students who in 5 years or so will be staffing our hospital floors, medical offices, and laboratories. Let us not turn them off by disallowing them the experience they need to maintain their enthusiasm. Please help through your influence with your local hospitals, nursing homes, and offices. Not only will these institutions realize the value of "extra hands" now, but they will benefit for years to come from having some of the brightest young people as future staff members.



Mrs. Louie H. Griffin, Jr. (right), Allied Health Careers Chairman, looks on as Mrs. Harry B. O'Rear presents the 1982 Silver Bowl Award to the winning high school club members and their sponsor.

(Reported by Mrs. Louie H. [Lou] Griffin, Jr., member of the Richmond County Medical Auxiliary, Augusta, and Chairman of the Allied Health Careers Clubs for AMAG.)

The Private Practice Option

The AMA has long been concerned with physician distribution and has encouraged private sector initiatives to deal with shortages where they exist. AMA recognizes that the distribution of medical practitioners can impact heavily on the degree of community access to health services. The AMA's approach to address maldistribution of physicians has focused on improving the attractiveness of practice in shortage areas. This approach emphasizes the use of incentives, education and encouragement, rather than legislation and regulation. As a result, the AMA strongly supports the National Health Service Corps' (NHSC) new direction toward private practice and has agreed to assist with the development and implementation of its Private Practice Option (PPO) program.

The NHSC was created to attract primary care physicians and other health professionals to practice in areas that lack adequate health manpower. A scholarship provision was authorized to assist students of the health professions who would agree to practice in a federally designated Health Manpower Shortage Area (HMSA).

Until recently, scholarship recipients were usually assigned to practice in government-approved health clinics to fulfill their scholarship obligations. In the last few years, however, the NHSC has shifted its emphasis away from federal placements. The obligated physician may now choose the PPO which allows the practitioner to establish in an HMSA, a private practice arrangement of his or her choice, independent of government funding and regulation.

The AMA has always supported the fundamental goals of the NHSC. The AMA's principal activity in the PPO program involves working with the medical community and other interested organizations to identify specific medical practice sites or opportunities that could be considered by those physicians who wish to choose the PPO. The identification includes an assessment of medical need, professional and community support, the practice resources available, and the potential success of the practice.

The benefits of the PPO, and of the AMA's involvement, are twofold. First, it allows for, and is dependent upon much greater input from the private sector and, in fact, may strengthen the role of private practice itself. Secondly, it encourages the new physician's involvement and commitment to the community in which he or she will practice.

For additional information on the program, please contact: Phyllis Kopriva, Program Director or Caryl Mendelsohn, Associate Director, PRIVATE PRACTICE OPTION/DEPARTMENT OF HEALTH CARE RESOURCES, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. (312) 751-5111 (or 6582).

MEDICAL MEETING CALENDAR

FEBRUARY — 1983

21-25—*Park City, Utah:* **Urology in the Wasatch Mts.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-26—*Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., Med. Coll. of Ga., Augusta 30912. PH:404/828-3967.

27-March 5—*Breckenridge, CO:* **8th Annual Snow Job in GYN/OB.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

MARCH — 1983

1-4—*Durango, CO:* **Sixth Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., Med. Coll. of Ga., Augusta 30912. PH:404/828-3967.

9-11—*Augusta:* **Electrocardiography and Cardiac Therapy.** Category 1 credit. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

24-25—*Atlanta:* **Practical Use of Antibiotics: Update For the 1980s.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27—*Augusta:* **Spring Meeting, Georgia Chapter, American College of Surgeons.** Category 1 credit. Contact LaMar McGinnis, M.D., 365 Winn Way, Ste. 201, Decatur 30030. PH:404/292-2700.

27-29—*Atlanta:* **MKSAP VI Part II — ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

28-30—*Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

28-30—*Augusta:* **Genetics for the Practitioner.** Category 1 Credit. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

APRIL — 1983

6-8—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

6-8—*Atlanta:* **Perspectives in Parenteral/Enteral Nutrition.** Category 1 credit. Contact Lynn Smith, RN, Program Chairman, Metabolic Support Svc., Ga. Baptist Med. Ctr., 300 Blvd., NE, Atlanta 30312. PH:404/563-4496.

7-8—*Atlanta:* **Otolaryngology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Lake Lanier Islands:* **Update of Hepatobiliary Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9—*Atlanta:* **Pharmacology For the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

8—*Atlanta:* **Neurology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10—*Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

10-14—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

11-13—*Atlanta:* **Pediatric Neurology: Currents and Controversies.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

15-16—*Atlanta:* **Atlanta Eye Congress.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

17-18—*Atlanta:* **Internal Medicine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24—*Atlanta:* **Postgraduate Course — Pancreas, Liver, and Biliary Tract.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

25-27—*Atlanta:* **Scientific Program of the Southeastern Surgical Congress.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

MAY — 1983

2-7—*Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Ms. Patsy Pennington, Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

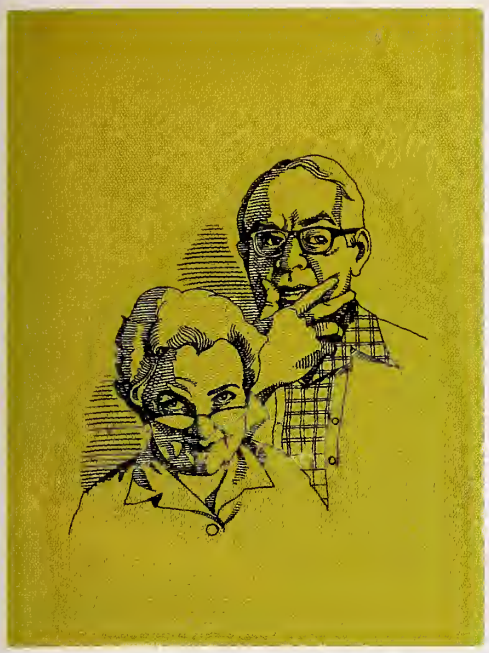
6-8—*Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., Div. of Postgraduate Ed., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

9-12—*Atlanta:* **Cardiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE Atlanta 30322. PH:404/329-5696.

12-14—*Atlanta:* **Pathology Update.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

18-22—*Atlanta:* **Family Medicine Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5696.

27—*Sea Island:* **Annual Meeting, Georgia Neurosurgical Society.** Contact Fremont P. Wirth, MD, #4 Jackson Blvd., Savannah 31405. PH:912/355-1010.








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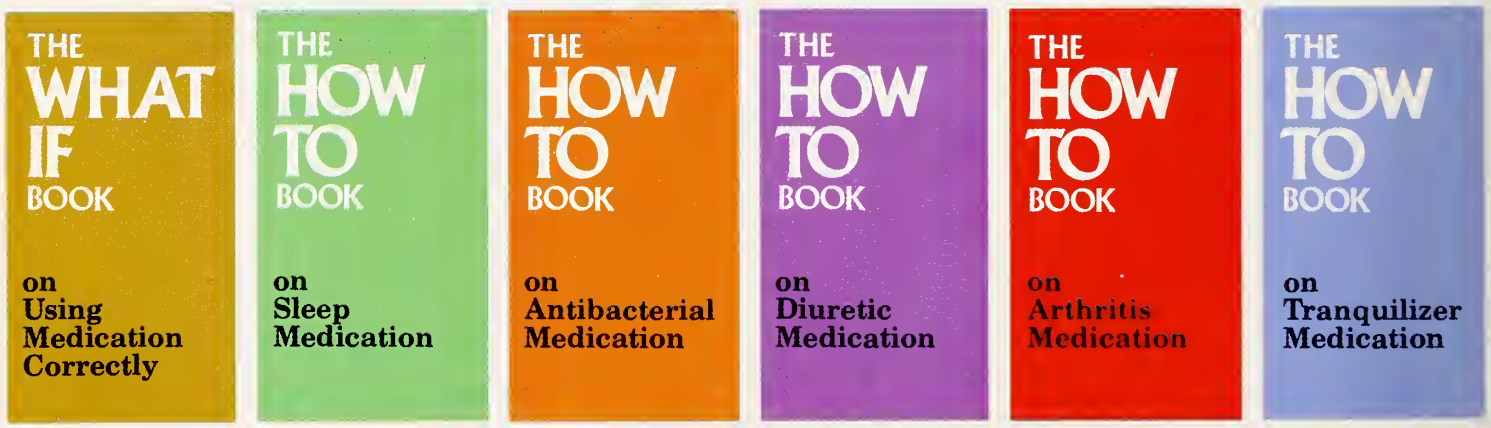
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An Introduction to This Special Issue



Mrs. Gay

THIS SPECIAL ISSUE of the *Journal* is the first of its kind in the history of this Auxiliary. It has a twofold purpose: (1) to give the reader a glimpse of what physicians' spouses do in support of the medical profession; (2) to regroup our own ideas and aspirations, based on the past and present, with a look toward what we hope to accomplish in the years ahead.

We have offered a "view from the top" by bringing messages from current national and state leaders who together guide the work of some 80,000 auxiliary members over the country. This year, the Georgia Auxiliary is fortunate to have one of its own members serving as president-elect of the Auxiliary to AMA. She will be installed as President in June and will be the third Georgian to hold this post.

The articles in this issue have been selected to point up some of the projects and activities which have been carried out, and sometimes originated, at the local (or county) level. Many of these have the possibility of being used by state and national components in their extended programs. Exceptional projects, however small they might seem, often receive nationwide attention and are deemed worthy enough to be placed in the AMA Auxiliary's Project Bank. Auxiliaries in all parts of the country may draw upon this storehouse for new ideas which may not have been tried in their own areas, but which could prove applicable with only a few modifications.

Some of the topics we have discussed are legislative activities, allied health careers clubs, the new Learning Center for school children, communications projects, medical student loan funds, child safety, and programs to help fight such "public enemies" as smoking, drug and alcohol addiction, scoliosis, mental illness, and obesity. Along with these efforts to help physicians to help others, we have not forgotten ourselves and the importance of keeping our own bodies and minds healthy. Doctors' Day, the Impaired Physicians Program, support committees for members of physicians' families, sports programs, and sometimes just private social functions to relieve tension and strain are among the activities in which we participate.

A Look at Our History

As we approach the beginning of the 60th year in our history as a state auxiliary, we can look back with some satisfaction at the progress we have made over the years. We began with only 23 women who signed on as charter members in 1924, and from that small number our organization has grown to include more than 2,400 spouses. It was at the 75th annual meeting of the MAG held at the Richmond Hotel

in Augusta, that the president of the newly formed Woman's Auxiliary to the Fulton County Medical Society (now the Auxiliary to the Medical Association of Atlanta) introduced the thought of having a state group composed of physicians' wives. Mrs. Floyd W. McRae appointed a committee of three, headed by Mrs. C. W. Roberts of Atlanta, to call a meeting of wives attending the Augusta convention with their husbands, in order to see how her idea would be accepted. Afterwards, a petition was addressed to the MAG House of Delegates for the women's group to be formed. The petition was granted and Mrs. James N. Brawner of Atlanta was named the first president of the Auxiliary.

Charter members included: Mrs. G. P. Bernard, Augusta; Mrs. James N. Brawner, Atlanta; Mrs. Allen H. Bunce, Atlanta; Mrs. J. J. Clark, Atlanta; Mrs. F. C. Colvin, Thomson; Mrs. C. W. Crane, Augusta; Mrs. D. W. Freeman, Valdosta; Mrs. J. D. Gray, Augusta; Mrs. G. Groover, Savannah; Mrs. Paul Holliday, Athens; Mrs. C. S. Lentz, Augusta; Mrs. H. J. Morton, Waynesboro; Mrs. K. W. Milligan, Augusta; Mrs. T. E. Oertel, Augusta; Mrs. H. Page, Atlanta; Mrs. E. Pund, Augusta; Mrs. R. L. Rhodes, Augusta; Mrs. C. W. Roberts, Atlanta; Mrs. W. H. Roberts, Augusta; Mrs. L. C. Roughlin, Atlanta; Mrs. E. O. Scharnitzky, Augusta; Mrs. W. H. Shaw, Augusta; and Mrs. V. P. Sydenstricker, Augusta.

The first annual meeting of the state auxiliary was held at the Biltmore Hotel in Atlanta on May 13, 1925. On the following day, Mrs. Brawner spoke before the House of Delegates of the Medical Association of Georgia. She told the members of that 76th annual meeting of physicians: "A wise man of the East prayed that he 'might see today with the eyes of tomorrow.' Would that we might have that power today that we might make no mistake in planning and laying the foundation of this new organization, the Women's Auxiliary to the Medical Association of Georgia."

Our name has changed since that historic day, but our purposes have remained the same. We have built each year upon the foundation laid down for us, and have increased our volunteer participation in many areas of life in the State of Georgia. We are pleased to have this opportunity to present some of our accomplishments in the pages of the *Journal of the MAG*.

Mrs. Brit B. (Evelyn Ward) Gay, Jr.
Guest Editor

Excerpts From Inaugural Address*

"Breathes there a man with soul so dead,
Who never to himself hath said,
This is my own, my native land?
Whose heart hath ne'er within him burned
As home his footsteps he hath turned
From wandering on a foreign strand?"

THESE WORDS of Sir Walter Scott express my deep love for this great nation of ours. As I thought of what I would say to you today, I was struck by the fact that the first word in the name of this organization is *American*. It stirred my thinking and my emotions. Being a naturalized citizen, I am forever grateful for this precious privilege, and I take the responsibility seriously. . . .



Mrs. Payne

I thank you for the great honor you have conferred upon me and on my state of New York. And I accept this enormous responsibility with pride and humility, ever mindful of the contributions of my predecessors who for 60 years have worked to build this auxiliary as a pyramid is built — block upon block and stone upon stone — until it stands as the great structure it is today. . . .

It is a thrilling and exciting time to be an American, and a thrilling and exciting time to be a member of this organization. For as we realize that we have given our government responsibilities far beyond its means and our pockets, we must help people learn again to do things for themselves instead of asking the government to do them. . . . We must show to all other nations what can be accomplished with unity and with America's most valued asset — the spirit of volunteerism upon which this country was built. . . .

I grew up in a very traditional family where volunteering was part of existing — as are eating, sleeping, breathing. . . . I began to volunteer at an early age. In fact, I met my husband when I was a Red Cross nurse with the Volunteer Aid Detachment during the Second World War and he was interning at the Royal Victoria Hospital in Montreal. . . . And as my early years will support me through this year, so the history of this great organization will support us as we move forward to be the leaders in the new call for volunteerism. . . .

It is on this history we have to build. Our country must be supported especially by us, for we are the conscientious stewards of mankind's noblest calling. We can do better than any of our counterparts anywhere else on this earth. In the tradition of our forefathers, let us therefore mutually pledge that the Americanism once worth dying for is now worth preserving against all its enemies, foreign and domestic. All it takes, fellow auxilians, is our commitment. . . .

All we have done as volunteers for medicine — our health programs, our fund raising, our legislative action — has been done because we care about this nation and the health of its people. . . . In the Old Testament book of Ecclesiastes, there is a verse that says, "A threefold cord is not quickly broken." Our threefold cord is our federated structure of national, state, and county levels. If we are united, if we maintain the strength of our federation, if we believe in the unity of the federation, then we will surely flourish. We need the support of every physician's spouse in this land in order to achieve our goals. . . .

We need to keep the interest of our present members and in addition to involve all segments of the medical spouse community — those who are male, widowed,

* From Mrs. Payne's speech at her installation to office at the annual meeting in Chicago on June 16, 1982.

foreign-born, living in metropolitan areas, as well as those who are married to retired physicians, residents, and medical students. We must not overlook any potential members in our campaign, for all are needed if we are to spread the messages of good health habits, needed funds for medical schools, legislative action for health. . . .

President Woodrow Wilson once wrote that, "America is not anything if it consists of each of us. It is something if it consists of all of us; and it can consist of all of us only as our spirits are banded together in a common enterprise." What is true of the nation is true of the AMA Auxiliary. We are nothing if we see ourselves as separate. We will succeed only if we join together, and that can happen only if our hearts are linked together in our common bond for our common goal. . . .

You, the members of the AMA Auxiliary, are the decision makers. You are the people supporting your spouses and your communities. You are vital to whether or not our work is successful. . . . It is up to us to preserve the traditions of those who have gone before, both in this nation and in this organization. . . .

It has been said that "only free peoples can hold their purpose and their honor steady to a common end, and prefer the interests of mankind to any narrow interest of their own." We are a free people in a free nation. We are volunteers in a great organization. Let us hold our purpose and our honor steady to reach our common goal of quality living and good health for all people in this nation.

Mrs. Torrence P. B. (Betty) Payne
President, AAMA
Newburgh, New York

From a National Viewpoint



Mrs. Bates

WHAT IS THE AMA AUXILIARY? It is a nationwide, volunteer organization of 80,000 physicians' spouses who use their talents and abilities to help people achieve and maintain maximum healthy living. It is a federated structure of county, state, and national organizations. That is the classic definition; but really, who are we?

— a volunteer organization with a history of 60 years of involvement in the health of the nation;
— a group of people whose community efforts have improved the lives of countless others;
— an organization which has enabled the nation's medical schools to continue a high standard of excellence;
— a group who protects the health of others through their legislative involvement.

What do you say to such a group? You tell them to be proud.

Of course, I'm talking about all of you in the Auxiliary to MAG. For you are the people who make the AMA Auxiliary what it is. You are the people whose work enables hundreds of thousands of people to live healthy, happy lives. You are the ones, you and your counterparts across this nation, who work for the common goal of improving the health and quality of life for all.

Successful implementation of these primary programs is possible only through the cooperative endeavors of county, state, and national organizations, each with its own range of activities which help all reach their goals. The national organization serves as an umbrella for activities, providing national programs; the state auxiliaries serve as coordinating bodies; and the county auxiliary is where all programs are implemented.

I say to you, take pride in your organization.

Take pride in being a volunteer. For in an age when no lesser person than the President of the United States is calling upon the nation's citizens to become involved in the country's well-being, we who are members of the AMA Auxiliary have already answered that call.

Our efforts are needed now more than ever. The changes in federal funding mean that services will be cut. We have already seen it happen. And we must be the ones to continue our long tradition of volunteerism to see that needs are met.

The six million associations estimated to provide voluntary services in this country are those which will help to maintain viable, needed health services. And the AMA Auxiliary is a leader among them.

Turf protecting is not viable in these times; isolation of program and personnel can lead to extinction. This is no time to fragment ourselves. The price of everything is going up — even freedom.

After serving on the national level for 9 years, I firmly believe it is imperative that every physician's spouse belong to county, state, and national auxiliary. WE NEED NATIONAL. Because the voices of 80,000 physicians' spouses, speaking as one, DO MAKE A DIFFERENCE. Because there is strength in sheer numbers, in shared visible concerns, in a unified voice to our community and legislators. Because we need to project a positive public image in behalf of the physicians in a time when they are being portrayed as self-serving.

Take pride in your organization. Take pride in your volunteer efforts. Take pride in yourselves.

When you consider what you as volunteers and members of the AMA Auxiliary have given to others, you should be proud. You have made change happen. You

have provided the services. You have helped people with different viewpoints communicate effectively. You have helped people find the services they need. You have driven the cars, tutored the children, read to the blind. You have made the decisions which have helped the lives of others.

The well-being of this nation is tied to your activities. You have made the commitment to improve your community and the lives of your neighbors without concern for personal profit. With your unfailing pursuit of good health, your willingness to give of yourselves to others, you have accomplished great things.

I say to you, take pride — in your organization, your volunteerism, yourselves.

To the physicians in the state of Georgia, I say, take pride in your Auxiliary. For within us is the potential for strengthening the nation through our efforts. Within us is the potential for creating a nation of healthy people, sound in mind and body. Within us is the potential to fulfill our dreams and our goals to help others.

As a leader of the AMA Auxiliary — our national organization — I ask you, auxilians with a common bond and a common purpose, and you, the physicians of this state — to let us join together, as partners, in seeking and meeting the health needs of the people of this state and of this nation so that we assure good health to every citizen.

Mrs. John G. (Glenda) Bates
President-Elect, AAMA
Cuthbert

Where Are We Going? A State View



Dr. Jones

WHEN WE ASK OURSELVES "where are we going" we realistically should ask ourselves where have we been and where are we now. From the beginning of our state Auxiliary to the present time, we have instituted and participated in many health-related projects. We know that one does not stand still; we either move forward or slide backward. Certainly, a year of being president-elect gives one the opportunity to observe what is going on, how to continue the programs that are working, and to evaluate objectively those that are not working.

One suddenly realizes that a year of being the president-elect or the president is just that — one year — which can be likened to a small spoke in a large wheel that is continually turning. That year is needed, but it is the total of the spokes that keeps the wheel in balance, and lets it continue to roll through the years.

We are probably at this time in our Auxiliary history in one of our most challenging and critical periods. At this point in time, we have undertaken one of the most exciting projects ever, the "Learning Center." This project will be expanded and carried on next year. With funding from the MAG and by diligent efforts from the president and health projects chairman, it is being taken all over the state. Positive responses are being received from county auxiliaries, schools, and interested organizations. What better way to reach the people than through health education?

We recently participated in a most informative activity which will help give us momentum to plan the future work of our state auxiliary — the 1982 Leadership Confluence. What is a leadership confluence? Webster's dictionary defines leadership as the "ability to lead" and confluence as "a gathering of people or things," so we have a gathering of people with the ability to lead when we talk about a leadership confluence. Let us amplify somewhat on what goes on at a leadership confluence.

The County President-Elect Leadership Confluence is held each October at the Drake Hotel in Chicago, and is sponsored by the AMA Auxiliary. What are the criteria for attending the confluence? First, the president and president-elect from each state are invited to attend. Next, the number of county presidents-elect invited to attend is based on one's state membership. Since Georgia has a membership of approximately 2500 members, it is allowed to send 7 county presidents-elect each year. How are these county presidents-elect chosen? They are selected on a rotating system. This is based on asking 7 county presidents-elect to attend each year, picking up from where the previous year's list stopped, and continuing on to the next county in line. If the one invited is unable to attend, then the next county on the list is invited to go. What about the costs for attending? The AMA Auxiliary pays the cost of the travel fare for each county president-elect, and the state auxiliary allows up to $250 for the hotel, etc. This year, for the first time, the state membership chairmen were invited, and Georgia's chairman did attend.

What exactly is offered at a confluence? Workshops, seminars, exhibits, consultations, brain-storming sessions, informal dinners, and outstanding speakers are the order of the day. From 8 a.m. until 8 p.m. one is there to learn, absorb, challenge, and speculate. This confluence is probably one of the most interesting and stimulating meetings a person will have the opportunity to attend.

The following seminars were offered at this year's confluence, from which each participant was able to choose six:

Parliamentary Procedure, Cooperation with Medical Societies, Public Relations, Working with Other Organizations, Time Management, Legislation How Tos, Intergenerational Programming for the Aged, Drug Use Prevention, Smoking Among Children and Adolescents, Child Abuse, Mid-Life Problems in the Medical Family, and Parenting.

With the changing times, two-career families, and the age of individual fulfillment, a challenging Auxiliary is a must if we are to continue to move forward. Are you ready to accept that challenge? I am, and I hope you are, because we must work together as a team if we are to meet that challenge.

Mrs. George R. (Judy) Jones
President-Elect, AMAG
DeKalb Auxiliary

Seminar
on
"How to Survive and Prosper as a Physician in These Changing Economic Times"

- **What "Competition" Means to Physicians and their Hospitals**
- **"Closing" the Hospital Medical Staff**
- **New Organizational Models (HMOs, IPAs, PPOs, etc.)**
- **Interfacing With Federal Reimbursement Policies Growth of Multi-Hospital Systems**

These Seminars provide physicians with an opportunity to analyze key issues affecting the delivery of medical care and point out the need to educate practicing physicians on the importance of effective quality assurance procedures in their practice.

March 18-20 **Longboat Key, Florida**
April 22-24 **Hilton Head, South Carolina**
June 16-17 **Kansas City, Missouri**

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Birmingham, Alabama 35201
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Your Key to CME



Auxiliary President's Letter

Pursuing Today's Potential

THE THEME CHOSEN by me as Auxiliary president this year is "Pursuing Today's Potential." Much emphasis has been placed on health education in order to enable our young people to learn more about themselves and appreciate the human body and how it works. Materials were carefully selected for the re-enforcement of the teaching of health education in our schools. Auxilians throughout the state are engaged in endeavors to raise funds that will place these learning materials in the hands of students and teachers, thus helping to pursue today's potential for a better educated world healthwise.

Auxilians are constantly pursuing today's potential. They are a powerhouse of some 2500 volunteers working together on county, state, and national levels to improve the quality of life. They are involved in support groups which are giving of themselves to others, or supplying the residencies of impaired physicians. They are found in shopping centers or elsewhere giving immunization shots or assisting in health screening programs. They conduct seminars on Parenting, Drug Abuse, Child Safety, Mental Health, and Physical Fitness, to name only a few.

Auxilians are concerned about legislative matters and are a viable way to measurably expand the legislative capacity of the Medical Association of Georgia. Each year more and more efforts are made to make the medical community more aware of legislation affecting them and to encourage them to speak out on issues affecting health care. This year a program called Key Contact has been started that will enable auxilians to have more personal contact with public officials on a one-to-one basis.

The role of the auxiliary is very encompassing. It is not only reflected in our community projects but in our homes as well. Through seminars and workshops, auxilians are encouraged to be good mothers and wives. It is the spouse who must cope with the carpools, demanding schedules, upset plans, and warmed-over dinners. When the M.D.'s spouse can accept these situations, not only will her life be happier but her physician-husband's as well. The public is the benefactor, for a happy doctor can concentrate on his profession.

Auxilians are a special "potpourri," or blend, that, when combined, generates concern for the family and home, the community, and good health for all. It is a challenge to belong to such a group that is continually striving to pursue today's potential.

Mrs. David C. (Barbara) Thibodeaux
President
Auxiliary to the MAG

Through this project, the Auxiliary has been able to assist the medical profession in its efforts to help educate the lay community for better health.

Health Education — "The Learning Center"

MRS. DENT W. (ANN) PURCELL, *Savannah**

A PRIORITY OF THE AUXILIARY to the MAG is to promote health education throughout our state. In order to provide more adequate health education curricula in the school system, we have focused our attention on the "Health Education Learning Center." This "Center" is an excellent permanent resource for teaching the biological sciences. It is designed to provide teaching aids for all achievement levels — pre-schoolers and students in grades kindergarten through 12. It consists of high quality, detailed instructional materials, and it has been approved by the MAG and endorsed by the State Board of Education.

The "Center" contains 3-dimensional models (human torso, heart, skull, eye, ear, and other anatomy parts), printed media, coordinated audio-visual material, and many other items which will provide "hands on" learning experiences. The plastic models are realistic, very detailed, and many can be disassembled for examination. The entire "Center" can be purchased for less than $2,000 or as individual items ($3 to $199).

"The Learning Center" has grown from the plans and leadership of Barbara Thibodeaux (Mrs. David), current President of the Auxiliary to the MAG. After several years of teaching in the elementary grades, Mrs. Thibodeaux felt the need for better instructional material in the classroom. A summer workshop was conducted recently for the entire Auxiliary Board. Each county auxiliary has since been contacted. This is a non-profit activity, and so far "Center" items have been distributed to 10 areas throughout our state.



(Left to right) Mrs. David C. Thibodeaux, President of the Auxiliary to the MAG, and Mrs. Dent W. Purcell, education chairman, look over a section of the Learning Center.

The Georgia Auxiliary presented the Health Education Learning Center during the Auxiliary-AMA National Convention in Chicago in June, 1982, and it received recognition as an excellent instructional technique. Also, an exhibit consisting of a slide presentation and a cassette explaining our project was presented in the Health Project display area during "Confluence" in Chicago in October of 1982.

The "Center" is an effective means by which the auxiliaries can be of service to their communities. The instructional materials can be used to teach health education concepts whether in the classroom, at home, or at a health fair. They can be used to re-enforce learned skills of health education in many areas.

Through this project the Auxiliary has been able to assist the medical profession in its efforts to help educate the lay community for better health, and to re-emphasize that "maintenance of good health is vital to quality living."

* Mrs. Purcell, Health Education Chairman of the AMAG, is a member and past-president of the Auxiliary to the Georgia Medical Society (Savannah), a former teacher, and holder of many posts in the Auxiliary.

Involvement and input into legislative decision making is becoming more and more vital. The Auxiliary has specific programs to facilitate this.

The Legislative Committee and Its Activities

MRS. WILLIAM C. (BARBARA) TIPPINS, JR., ***Dunwoody****

GOOD HEALTH CARE for all people has always been the prime objective of doctors, medical societies and auxiliaries all over the state and nation. Good medically related legislation is also of prime importance to the professions supplying the health care. Necessarily, then, involvement and input into the decision making is becoming more and more vital.

The medical societies and their auxiliaries are finding it most important for the legislators to hear their voices and opinions as to what they feel will best serve the people.

The Legislative Committee of the Auxiliary serves two purposes: to keep members informed on legislative health issues facing organized medicine and to involve the Auxiliary in working for good health legislation — "Let their voices be heard."

The Auxiliary to MAG and the county auxiliaries, as well as the national Auxiliary, have developed programs which establish activities to help promote successful legislation. These activities focus on legislative action rather than political action. A working definition of *legislative activity* is: any activity calculated to influence the status of pending bills before a legislative body; *political activity* is defined as any activity within the realm of the electoral process.

This means that our efforts will be to see that good health legislation is introduced and made into law, and that less desirable bills are modified or not passed. To educate and motivate members to action when needed is our most important responsibility.



Mrs. William C. Tippins, Jr., Third Vice President and legislative chairman, gives the Auxiliary members pointers on the legislative process. Mrs. James Manning (right) is the Parliamentarian.

All of the Legislative Committee's activities must have the approval of the MAG Advisory Committee and/or the county medical society.

In the past, auxiliaries have conducted letter-writing campaigns urging particular legislative action on specific legislation; sponsored workshops or meetings where they furnished speakers, planned the programs, prepared and distributed pamphlets or literature; held a "Day at the State Capitol" program while the General Assembly was in session; organized and used the Legislative Alert System, or other communication devices for transmitting legislative information to the auxiliary members.

The Auxiliary to the American Medical Association's motto is "Involvement Tips Scales," and the

* Mrs. Tippins, a past-president of the DeKalb County Auxiliary, is Legislative Chairman of the Auxiliary to MAG. She has also served as an assistant editor of *Pulse Line*.

adaptation of it for this year is "It's Up to You." It *is* up to you to become involved in the legislative activities planned for you by your chairman and your president.

One area of concern, *A Legislative Liaison Relationship Between Medical Societies and Auxiliaries,* is being addressed this year by the national committee and encouraged by the state Legislative Chairman of the Auxiliary. The Legislative Committee of MAG has placed the Auxiliary Legislative Chairman on its committee this year. County auxiliary chairmen may wish to follow in this activity on a local level.

The two essential components in a legislative liaison relationship are: (1) the Auxiliary and (2) the medical society. The Auxiliary must be committed to the project, follow through, and persevere in its efforts to form this relationship smoothly. The medical society president must want the involvement of the Auxiliary. A good rapport must be developed with the committee chairman. Start with a small project, do it well, be reliable, and be alert. Watch for additional opportunities to demonstrate the effectiveness of having a legislative liaison relationship between medical society and auxiliary. An auxiliary's ongoing responsibilities are to:

1. Be reliable. Do what you are asked to do and do it well.
2. Be alert. Look for opportunities to be involved that the medical society may not have thought of.
3. Keep your commitment constant.
4. If you have already established a legislative liaison relationship with your medical society, go to the legislative committee meetings — all of them. If you cannot go, send a substitute.

Another new activity which the AAMA believes can be most effective is the *Resource Person* or *Key Contact Person Program.* A medical resource person is someone who already knows or is willing to get to know a U. S. or state legislator on a one-to-one basis. The goal is to get a legislator to call on this resource person to discuss aspects of medical bills. In the same way, the resource person can contact the legislator when emphasis needs to be given as to the good or harmful effects of pending legislation. This program is more effective when the key person is from the same neighborhood or voting district as the legislator. It is important for the key person to learn some of the background information about the legislator — hobbies, schooling, family, profession, or vocation.

How to meet or get to know the legislator may be a concern of some key contacts, but a letter of introduction explaining the program and your wish to be helpful to him as a source of information might be one way of getting to know him. Ask someone who knows him to introduce you. Invite your legislator to speak for a local community meeting or at your auxiliary meeting. Or a simple, straightforward phone call telling him of this activity may suffice. If your legislator needs technical or specific knowledge you do not know, tell him so and that you will get back to him with the correct information, and then do it.

If you feel that you could not be a key contact person because you do not understand the legislative process or do not feel confident that you could speak knowledgeably on a specific medical issue, join the club! No one expects you to be an expert on any medical issue; but you could spend some time reading a few articles on legislative issues concerning medicine, and your local or state medical society and auxiliary can be helpful also.

Legislators have voiced their need to have doctors or some one as a resource person for gaining specific knowledge on some issues; they welcome a visit to their offices, a visit in your home, a personal phone call, or a hand-written note. A real, ongoing friendship could be an outgrowth of the Key Contact Person Program.

Auxiliary members should make it a personal goal to know who their legislators are and how to address mail to them. Not everyone has the time or inclination to become a contact person, to be a liaison to the medical society, or to serve as an alert system chairman, but each person should be able to write a letter if the need should arise. There is something for everyone in legislative activities. Be alert, become informed, become involved, and always exercise your right to vote for the person of your choice.

The ideas used to observe this special day are as varied and thoughtful as the people are who reach out to touch others with kindness.

Doctors' Day — Founded By a Georgian

MRS. MILTON B. (ANN) SATCHER, JR., *Atlanta**

WHEN A LITTLE GIRL in Fort Lamar, Georgia, cut her hand on broken glass, it was the beginning of another "first" for Georgia.

That little girl became Mrs. C. B. Almond, of Winder, who founded Doctors' Day. The day is celebrated annually on March 30, the date which also commemorates the first use of ether as an anesthetic in a surgical operation by Georgia's own Dr. Crawford W. Long. The observance is marked in several foreign countries as well as throughout the United States.

Near the turn of the century, Mrs. Almond was little Eudora Brown, living on a large plantation at Fort Lamar. She cut her hand when she dropped a glass of milk. It was the cut hand which perhaps influenced her entire life, she once recalled.

To the little girl, Dr. A. L. Payne, the family doctor, was the "miracle man" who came to her home driving his horse and buggy and "made the cut well." She never forgot that particular miracle of healing.

When she grew to young ladyhood, her only thought was to enter nursing school and begin a career "of helping people and giving health and sometimes happiness." She was capped in 1919 at Davis-Fischer Sanitarium, now Crawford W. Long Hospital. The following year she married Dr. C. B. Almond and moved to Winder, where she and Dr. Almond lived in a big, rambling 12-room house, surrounded by a flower garden. She continued to live there until her death in 1982.

"The doctors were to me the unsung heroes," she said, "and I always wanted to do something to pay tribute to them in some way. I wanted something that would be lasting, and which would focus the attention on them as an annual event. My husband was a great inspiration to me and his great work with the sick brought the humanitarian angle closer to home."

It was in 1933 that Mrs. Almond conceived the idea of the day which now has worldwide interest. She presented to the members of the Barrow County Medical Auxiliary the idea of establishing a Doctors' Day, and persuaded them to adopt a resolution proclaiming March 30 as an appropriate day for honoring their doctors. On May 10, 1934, the state Auxiliary adopted a resolution at the annual meeting in Augusta proclaiming March 30 as Doctors' Day. The idea was presented the following year to the Auxiliary to the Southern Medical Association and to the Auxiliary to the AMA by Mrs. J. Bonar White, of Atlanta, who was first vice president of the AMA Auxiliary.

Mrs. Almond worked tirelessly to see that Doctors' Day became a national observance. She carried on correspondence with chairmen throughout the United States, and had a fascinating collection of Doctors' Day memorabilia tracing the history of her idea. The first idea was to send each doctor in her county (Barrow) a red carnation to wear on this special day. The custom spread and the flower is now an accepted symbol of the day.

The observance of Doctors' Day continues to be an active project in every county auxiliary and is emphasized in many ways. It is an ideal opportunity to further good public relations for the medical profession.

* Mrs. Satcher, who has been president of both her county and state auxiliaries, has filled many roles in auxiliary work at local, state, regional, and national levels over the past 20 years.



Dr. and Mrs. Perry M. White (left) and Dr. and Mrs. James W. Morgan (right) are shown with NASA Astronaut Dr. James P. Bagian who spoke to members of the Medical Association of Atlanta and auxiliary members in celebration of Doctors' Day.



Governor George Busbee signs a proclamation designating March 30 as Doctors' Day in Georgia as Mrs. David C. Thibodeaux (far right), 1982-83 President of the Auxiliary to the MAG, looks on with, left to right: Mrs. Armand A. De La Perriere, Mrs. Charles B. Upshaw, Jr., Mrs. James W. Morgan, Mrs. Perry M. White (1981-82 President of the Auxiliary to MAG), and Mrs. Charles G. Rogers, all of the Auxiliary to the Medical Association of Atlanta.

Some of the ideas used to observe this special day are:

1. Red carnations, symbol of Doctors' Day, are used in arrangements which are placed in hospital lobbies, churches on Sunday nearest to March 30, physicians' offices, graves of deceased physicians, at dinners, buffets, coffee hours, or luncheons given in honor of physicians.

2. Contributions are made to State and National scholarship funds such as AMA-ERF and the William R. Dancy M.D. Student Loan Fund, and to local funds such as rescue squads, high school health clubs, or other health-related community organizations.

3. Health-oriented magazines, books written by or about physicians, or local medical society histories are placed in schools, colleges, hospitals, or public libraries.

4. A special room is furnished in a hospital or a nursing home; sleeper chairs are provided in pediatrics wards for parents staying with their children; or a fragrance, herb, or shrubbery garden is planted in honor of physicians.

5. Social activities to promote fellowship among doctors' families with picnics, barbecues, etc. are planned, including single and retired physicians, doctors' widows, and in some cases, interns and residents.

6. Personal messages are sent to physicians' widows and retired physicians.

7. Physicians are encouraged to have medical checkups.

8. Physicians who have practiced 30 years or longer, or are noted for some outstanding achievement or contribution, are honored.

9. All members are urged to participate in planning for this special day.

Each year the Auxiliary to the Medical Association of Georgia offers awards for observances of Doctors' Day. These include a silver bowl and a tri-color ribbon for the best overall observance. Color ribbons are given in each of two categories: auxiliaries with membership under 100, and auxiliaries with membership over 100. Exhibits are judged at the annual convention, and the best overall winner is presented at the convention of the Auxiliary to the Southern Medical Association.

At the Southern Medical Association's convention, monetary awards and honorable mention certificates also are given for the most original, outstanding, and unique observances of Doctors' Day. The George D. Feldner Trophy is presented to the county auxiliary submitting the best overall observance of Doctors' Day, regardless of size of membership. The Guy Smith Kirby Trophy is awarded to the county auxiliary submitting the second best overall observance, regardless of size of membership.

And so out of the gratitude of a little girl for her kindly family physician, and from the loving heart of a doctor's wife, so justly proud of her husband whose work was his glory, emerged a most beautiful tribute to the medical profession — Doctors' Day.

AUXILIARY MEMBERS ON MAG COMMITTEES

This has been a privileged year for the following auxilians who have been appointed to MAG committees by Dr. Charles D. Hollis, Jr.



Access to Health Care
Mrs. Carl Pittman, Jr.



Cancer Committee
Mrs. Brit B. Gay, Jr.



Committee on Drugs
Mrs. Milton B. Satcher, Jr.



Committee on Education
Mrs. Dent W. Purcell



Emergency Medical Services
Mrs. Mark M. Lindsey



Committee on Legislation
Mrs. William C. Tippins, Jr.



Maternal and Infant Health Care
Mrs. Alva Mayes



Medical Aspects of Sports
Mrs. William McWhirter



Medical Practice
Mrs. George R. Jones



Medicine and Human Values
Mrs. W. Jack Smith



Membership Insurance
Mrs. Earl B. Benson



Nursing
Mrs. Harry B. O'Rear



Nutrition Committee and Crawford W. Long Memorial
Mrs. David C. Thibodeaux



Prison Health Care
Mrs. Frank Isele



Public Health
Mrs. Maurice Patton



Public Relations
Mrs. Robley D. Smith



Risk Management
Mrs. Perry M. White



Third Party Relations
Mrs. Russell Andrews



Mrs. Eugene C. Clark
Transfusions and Transplantations



Women Physicians in Organized Medicine
Mrs. Mark Brown

Not pictured here are Mrs. Luther Clements, Jr., Impaired Physicians Committee; Mrs. Charles Underwood, Mental Health; and Mrs. Myron Katz, Physicians' Assistants.

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Reference: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document, ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980, pp 10–15.

MELFIAT® 105 UNICELLES®

(phendimetrazine tartrate) 105 mg

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Please see brief summary of prescribing information on the next page.

A Brief Summary
MELFIAT® 105 UNICELLES® Ⓒ
(phendimetrazine tartrate) 105 mg Slow Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a slow release dosage form, limit to one slow release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear slow release capsule contains 105 mg phendimetrazine tartrate in bottles of 100. NDC 0063-1082-06.

CAUTION: Federal law prohibits dispensing without prescription.

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Everyone has an excuse for not seeing their doctor about colorectal cancer. However, every year 52,000 men and women die of colorectal cancer in this country alone. Two out of three of these people might be saved by early detection and treatment. Two out of three.

So what is your excuse? Today you have a new, simple, practical way of providing your doctor with a stool specimen on which he can perform the guaiac test. This can detect signs of colorectal cancer in its early stages before symptoms appear. While two out of three people can be saved. Ask your doctor about a guaiac test, and stop excusing your life away.

American Cancer Society

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THIS SPACE CONTRIBUTED AS A PUBLIC SERVICE

Knowing that we can help prevent the pain, despair, and deformity of this disease in this generation makes our time and efforts worthwhile.

Detecting Scoliosis — A Vital Program

MRS. JOHN F. (BARBARA) McCOY, JR., ***Tifton****

THE TIFT COUNTY MEDICAL AUXILIARY has conducted a Scoliosis Screening Program in grades 5 to 9 for the past three years, a project which can serve as a model for other areas of the state. Over 4,000 students in 6 schools have been screened since the project began in 1980. Hundreds of hours have been spent in the planning, training, promoting, and implementing of this program. Each year at least 20 auxiliary members have participated, which represents 60% of the Tift County Medical Auxiliary membership.

Interest in the project was stimulated initially by the showing of the film "Spinal Screening," which was produced by the American Academy of Orthopedic Surgeons. Working under the encouragement

* Mrs. McCoy is a member of the Tift County Auxiliary.



Dr. James Scott, orthopedic surgeon, assisted the Auxiliary in scoliosis screening program in Tift County.

and direction of local orthopedic surgeon, Dr. James Scott, the Health Education Committee of the Tift County Medical Auxiliary began the massive job of designing a plan to screen over 1,500 students the first year.

The first step was to present the need for a Scoliosis Screening Program to the Tift County Board of Education. Once approval to conduct a screening program was secured, Medical Auxiliary members began to work with the principal of each school to set a time, place, and a definite plan for screening. Each year the principals and faculties have continued to cooperate with this project because they have seen first-hand the need for such a program.

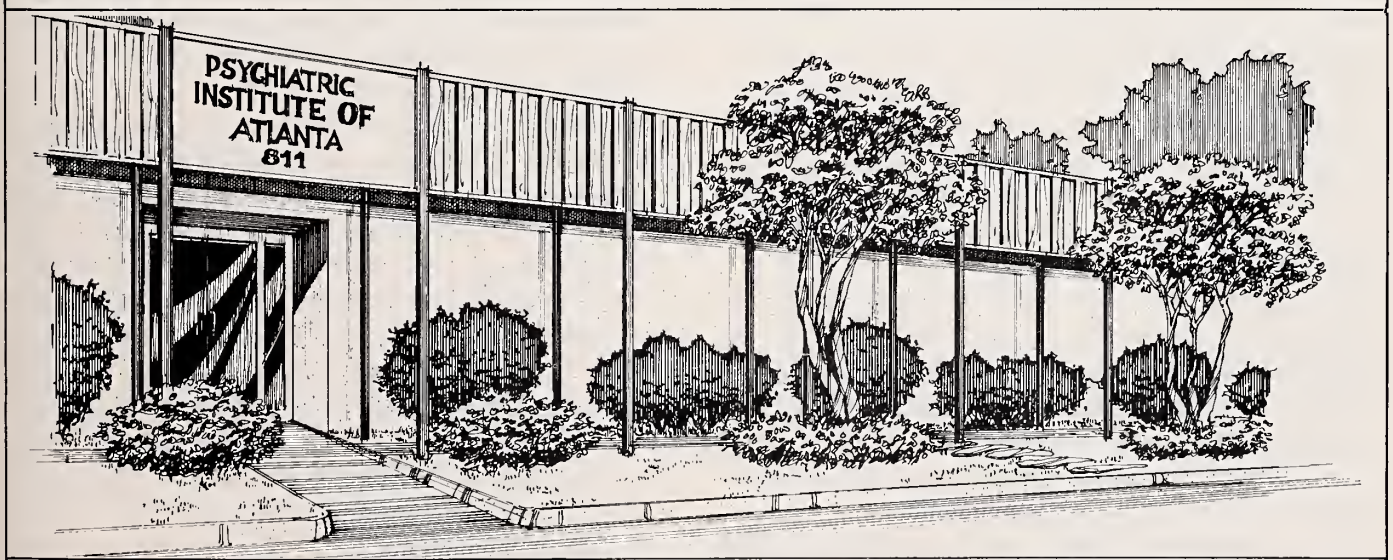
The weakest link in the program thus far has been the difficulty in obtaining parental permission for some children to be screened. Because Georgia does not require legally that scoliosis screening be done (as does the State of Florida), a child cannot be screened without written permission. Approximately 25-30% of the students targeted for screening in Tift County the last 3 years have failed to participate in the program.

Each year letters of information are prepared and given to every student scheduled for screening. Parents are asked to read the information and sign the permission slip. In addition, pamphlets on scoliosis (donated by the Georgia Easter Seal Society) have been sent to parents; newspaper articles have given additional publicity. Dr. Scott has presented several PTA programs on scoliosis to increase and encourage parental concern for the problem.

The results of this on-going project continue to be both startling and gratifying. Scoliosis definitely is a health problem in Tift County among children 10-15 years of age. Approximately 5% of those screened have required further evaluation with x-rays. It is estimated that 25 students have needed non-surgical treatment for scoliosis and several have required major surgery because the screening program was not early enough for them.

The goal of our project is to detect signs of scoliosis in the early stages in order to prevent deformity and disability. Screening hundreds of boys and girls each year is physically and mentally exhausting, and one is tempted to ask, "Is it worth it?" The satisfaction comes in knowing that many children are now being treated successfully for scoliosis who otherwise would not have been diagnosed until the problem became severe. Knowing that we can help prevent the pain, the despair, and the deformity of scoliosis in this generation makes our time and efforts worthwhile.

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Each participating auxiliary was encouraged to implement a radio program as a community service.

The Communications Project

MRS. HENRY D. (BEBE) MEADERS, *Marietta**

The Communications (now Radio/TV Spots) Committee has had an interesting and varied life. The concept for such a program was conceived in 1979 when Georgia's Auxiliary President-elect Ann Satcher attended the AAMA Leadership Confluence in Chicago and consulted with other state presidents-elect about their on-going and planned projects.

A communications program, first begun by the North Carolina Medical Association and implemented by the North Carolina county auxiliaries, was of particular interest. This program was designed to have tapes made of local physicians being interviewed by local auxilians. The subjects of the tapes were chosen to be of local interest, and the tapes were played over local radio stations. The word *local* is used repeatedly because the aim was to improve the doctor's communication with the community in which he practiced.

Thorough investigation for a similar program to be begun in Georgia led to MAG approval and assistance. Letters were written to Georgia auxiliary county presidents asking them to appoint communications chairmen and have these chairmen come to the Summer Board meeting to be held at Callaway Gardens in 1980.

The Medical Division of Burroughs Wellcome Company, which had developed the program for North Carolina, agreed to work with the Georgia Auxiliary, and MAG offered to provide physicians and staff to help with the workshop. At this meeting, the Auxiliary president and president-elect from North Carolina, 10 MAG physicians and several staff members from MAG headquarters, Burroughs Wellcome representatives, and a large number of auxilians — working in small groups — practiced interviewing techniques and made tapes on a variety of medical subjects. We learned that we *could* handle microphones, tape recorders, stop watches, and other recording equipment with surprisingly proficient results.

Each participating auxiliary, with the approval of its medical society, was encouraged to implement a radio program as a community service. Basic equipment was made available, and suggested outlines for interview questions were provided. The fledgling program had been launched with interest and enthusiasm.

Other aspects of communication were also discussed at the workshop. Some Georgia medical societies had already established radio or TV programs, and suggestions were given as to how auxilians could support and participate in them. Closed-circuit hospital TV was also proposed as another channel for a communications project.

Since its beginning in 1980, 15 or more Georgia auxiliaries have participated in various segments of our communications program, and at least two other states have expressed interest in starting a similar project. We are particularly grateful to MAG for its continued support in this endeavor. They have conducted mini-workshops for interested auxiliaries, and Ken Williams, MAG Public Relations Director, continues to act as a resource person to any auxiliary wishing to begin or rejuvenate a program. MAG also distributes TV spot announcements throughout the state on Shape-Up-For-Life, Organ Procurement, and other medically related subjects.

Communication has been defined as the art of telling, informing, making acquainted with, advising, conveying knowledge, having interchange of thoughts and ideas. We believe our Auxiliary's program has made it possible for this definition to become a reality in the medical community.

* Mrs. Meaders is a member of the Cobb County Auxiliary, Radio/TV Spots Chairman for AMAG, a former editor of *Pulse Line*, and a former regional editor of *Facets*, publication of the Auxiliary to the AMA.

A report on the Fund's beginnings and current status.

The William R. Dancy M.D. Student Loan Fund

MRS. WILLIAM N. (JO) AGOSTAS, *Augusta**

THE WILLIAM R. DANCY M.D. Student Loan Fund had its beginning in 1930, at the suggestion of Dr. William R. Dancy, of Savannah. Mrs. Allen H. Bunce, of Atlanta, was chairman of a committee which drew up plans and the first rules. The fund was adopted as a project of the Auxiliary to MAG in 1930. The method of raising money for the fund was the same as it is today. The original committee report stated: "The money shall be obtained from the county auxiliaries and from outside donations. The goal set for each auxiliary member is $1.00 per year, and preferably $2.00."

The project was called the Student Educational Fund, then the Student Loan Fund, and in 1956 the name was officially changed to the William R. Dancy M.D. Student Loan Fund. In 1969 the properties owned by the loan fund were transferred to the Medical Association of Georgia Foundation, Inc. The Auxiliary still maintains the management of the fund and is assisted by the Medical Association of Georgia in all legal matters.

The financial record book begins with the year 1937. There was $325.15 in the fund at the beginning of that year, and during the year, four young doctors made payments on their loans in the amount of $227.00. Most of these payments were at the rate of $15 to $25 each. In that year, donations from county auxiliaries amounted to $254.35. For the next 17 years, the donations seldom went above this figure. The average donation was slightly more than $200 for all the auxiliaries combined, from 1936 to 1954.

By 1939-40, the fund had increased to slightly over $2,000, and one loan of $300 was made. Then, during the next 3 years ending in 1943, loans were made to four students, totalling around $2,500. Probably due to the effects of the GI Bill, no further loans were made during the next 4 years. From 1947 to 1954, four loans for $600 each were made.

When Mrs. Shelley C. Davis, of Atlanta, ended her 3-year chairmanship in 1953, she reported the results of a survey she had made of other loans and scholarships available to students in Georgia. Her study showed that there were quite a few scholarships and loan sources with less restrictions than ours. She suggested that our rules might be re-evaluated in the light of these findings. At this time there was almost $6,000 cash balance in the fund, plus two $1,000 War Savings Bonds.

In 1954-55, loans totalling $5,280 were made to 10 medical students, and the following year, $2,160 to five students. This tremendous increase was probably due to three factors: (1) slackening of restrictions to accept applications from married students, etc.; (2) end of the GI Bill assistance; (3) better publicity about the fund.

The present bank balance is around $2,341.50 and the net worth of the fund is approximately $83,785.48. We now lend money to students who are charged no interest while they are in school and for 6 months after they graduate. Six months after graduation, we charge 9% interest. In the event the doctor fails to contact the chairman of the fund each year, or fails to pay anything on the loan, the committee can call the loan payable and demand regular bank interest. This is stated in the note which each borrower signs when the loan is obtained.

As stated above, the donations from county auxiliaries, prior to 1954, were far short of the hoped-for minimum of $1.00 per auxiliary member. For 1953-

* Mrs. Agostas is chairman of the William R. Dancy M.D. Student Loan Fund and resides in Augusta where she is a member of the Richmond County Auxiliary.

54 the amount had dropped to $124 for the entire state membership. However, with the sudden increase in demand for loans, the auxiliaries jumped their contributions to $1,285 in 1955. This amount continued to be received until 1975. From 1975 to 1982, at least $2,500 has been given by the auxiliaries. A donation of $4,000 was made by Mrs. William R. Dancy in 1966, and in 1968 the Chatham County Auxiliary gave $1,910.55. The 1977 MAG Board gave $4,016; the 1979 MAG Board gave $4,000; and in 1980, a gift of $596.25 came from Mr. L. B. Storey of the MAG staff.

A total of 185 loans have been made since the fund's beginning in 1930. Due to a great demand for loans, the William R. Dancy M.D. Student Loan Fund Committee is asking each Auxiliary member to be especially generous in giving to the fund this year. Please remember that Memorials can be given to the fund in memory of both living and deceased persons. Appropriate cards are available from the chairman upon request.

The current committee consists of Mrs. William N. Agostas, Mrs. Mark Brown, Mrs. Louis H. Griffin, all of Augusta, Dr. Dorothy Brinsfield, of the Emory University School of Medicine, and Dr. James B. Puryear, of the Medical College of Georgia.

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The diversity and extent of the auxiliaries' activities throughout the state may surprise you.

Highlights From the Counties

MRS. ROBLEY D. (ANN) SMITH, *Tifton**

IT HAS BEEN A BUSY year for all of our auxiliaries. Many have done outstanding projects and have also had lots of fun and fellowship with one another. Some of them are spotlighted in the following accounts:

BIBB COUNTY's big project was gaining approval for RAMP Substance Abuse Program as a pilot in the Bibb County schools. Teacher training and needed curriculum guidelines were provided. Many volunteers were involved in collating materials, providing refreshments, and substituting so that teachers could be released for training sessions. The Bibb County Medical Society allocated $2,500 in addition to the Auxiliary budget for this worthwhile project.

Bibb County Auxiliary also cooperated with the Pilot Club and Health Department on a project promoting safety-approved infant car seats.

COBB COUNTY AUXILIARY members are still very much involved in running their hospital gift shop. This is their main project which involves the efforts of a great many of their members and brings in an impressive sum of money each year to furnish much-needed equipment for Kennestone Hospital.

CRAWFORD LONG AUXILIARY manned a booth for pre-school vision screening at the 2-day Health Fair. It was a great success.

DEKALB COUNTY sponsored a symposium entitled, "Today's Adolescent." They also continue to circulate and sell their low-cholesterol cookbooks. According to Margaret Syribeys, president, "Recognizing the great number of individuals who suffer from coronary disease and realizing that diet plays an important role in its control, the DeKalb Auxiliary published a low-fat cookbook, *A Way of Life,* in 1973. The proceeds from the book sales were designated at that time to be used by the committee for future community projects. It is the feeling of the membership that it would be most appropriate for the projects to be in the area of heart care. Therefore, this year, after investigating the needs of the community, a decision was made to purchase for DeKalb General Hospital a video cassette machine with a cart, films, and slide presentations that will be used in education programs to help cardiac patients deal more effectively with their illness. . . . We are making these purchases to help set up a quality audio-visual library for the cardiac patients. We will also purchase a much-needed Doppler machine. This will make reports to the physicians more accurate and meaningful. The total cost of this project is $2,700.



Mrs. David C. Thibodeaux (right), state president, and Mrs. Hugh S. Colquitt, of Marietta, check out some of the gift items sold in the Cobb County Auxiliary's shop at Kennestone Hospital.

"Also this year," says Mrs. Syribeys, "the DeKalb County Auxiliary will use the profits from our annual Community Holiday Card project to purchase a series of health education films for the DeKalb

* Mrs. Smith is a member of the Tift County Auxiliary and is Second Vice President and Program Chairman of the Auxiliary to MAG.

County School System. The films are made by the Walt Disney Studios in conjunction with the President's Council on Physical Fitness and Sports, and are entitled 'Fit to be You' and 'Fitness for Living.' The cost of this project is $1,600.''

DOUGHERTY COUNTY has too many projects to report them all. They presented the ''Arnie the Aardvark'' smoking education program for second graders in all the public schools in their county. They also co-sponsored a tremendously successful Health Fair, held a Red Cross Blood Drive, and did work with substance abuse along with many other projects.

''Arnie the Aardvark,'' the fearless foe of smoking, was born 8 years ago in Athens, the brainchild of Beth Rutherford of the Clarke County Unit of the American Cancer Society. The Dougherty County Medical Auxiliary adopted Arnie in 1980 in cooperation with the Local Unit of the American Cancer Society.

Arnie the Aardvark is a 5-foot, 7-inch hairy green costume, ably filled by extroverted auxiliary members who are anxious to carry the anti-smoking message to all second grade students in Dougherty and Lee Counties. In 1982, over 2,000 students in 20 schools participated in Arnie's program.

At the beginning of each 20-minute presentation, the eager second graders are greeted by Arnie, who questions them about the concept of ''being healthy.'' Then a 6-minute film, ''The Huffless, Puffless Dragon,'' is shown. This is an American Cancer Society film starring ''Dragoon'' and all his huffless, puffless dragon friends who smoke and smoke until they lose their health.

Following the film there is an active question and answer period during which the children are encouraged to caution their relatives and friends not to smoke. The program concludes with a song about the dangers of smoking to the tune of ''Old McDonald Had a Farm.''

The response to this program has been overwhelming, according to Donna Myler, American Cancer Society Regional Staff Executive. Principals, teachers, and students have swamped the Auxiliary with letters and requests for repeat performances. Students are touched by the influence they can have on smoking friends and relatives.

Through Arnie the Aardvark, the Dougherty County Medical Auxiliary has learned that the little children shall truly lead them.

(Inquiries about this program may be addressed to Mrs. Sam L. Strickland at 1711 Lowell Lane, Albany, GA 31707.)

FLOYD-POLK-CHATTOOGA AUXILIARY has been active this year in the teaching of the book ''Marijuana — Time for a Closer Look.'' This is a textbook geared to teenagers and has been introduced into the public schools. They sponsored a cardiopulmonary resuscitation course, continued working on an orientation program for children entering Redmond Park Hospital, and also emphasized meeting the needs of the elderly in their community.



Dr. John T. Yauger, President of the Medical Association of Atlanta, and Mrs. Yauger, left, admire one of the drawings of Shutze homes which were featured at a champagne reception preceding the Atlanta auxiliary's tour of homes to raise funds for the Academy of Medicine restoration. Artist Tom Fletcher and Mrs. Fletcher, of Juliette, Ga., are at right.

Floyd-Polk-Chattooga was the first auxiliary to purchase the entire ''Learning Center'' (see article on page 93), and it has been made available to more than 24,000 students and teachers in public and private sectors by placing it in the Floyd County Media Center.

Other projects undertaken by this active auxiliary are: Continued assistance to the Floyd County Health Department by furnishing auxiliary volunteers to teach sexual awareness and pregnancy prevention classes at the Family Planning Clinic; a drive to reach out, inform, and educate all of the citizens in the 3-county area on child passenger safety; a ''Quality of Life'' collection of books in a lending library on the subjects of children leaving home, menopause, personal relationships, etc.; and a rewarding project called ''Nursery,'' which provides sitters for young children and transportation to and from auxiliary meetings for members.

One of the most heartwarming and thoughtful activities of the Floyd-Polk-Chattooga Auxiliary is their Support Committee by which effort is made to strengthen the friendship and fellowship between members by such acts as delivering hot meals to new fathers, serving food to those members' families who have some pressing need, and by simply writing letters of encouragement and hope to let an auxiliary member know that there are people who sincerely care.

GEORGIA MEDICAL AUXILIARY in Savannah has been active in a variety of projects. They held their second annual Doctors' Run with proceeds



Left to right, Dr. Gwynn T. Brunt, Dr. T. Roderick Hester, Jr., and Dr. and Mrs. Charles G. Rogers relax at an orientation reception for new members of the Medical Association of Atlanta held at the Cherokee Town Club in Atlanta. Mrs. Rogers is a past president of the Atlanta auxiliary.



Mrs. William J. Pendergrast, second from right, presented $500 scholarships to nursing students (left to right) Laura Haskoven, Burness Bankston, and Bonnie Wolf. These scholarships were awarded by the Auxiliary to the Medical Association of Atlanta.

going to the American Heart Association. They are continuing their participation in showing the puppet show, "Live It Up Naturally," in the schools of their area. Proceeds from a tennis tournament went to the Safe Shelter of Savannah. They joined with the Heart Association in a Blood Pressure Screening program, and sponsored a "Good Emergency Mothers Substitute Course" for training baby sitters. According to Ann Purcell, of the Georgia Medical Auxiliary, the 2-day clinic for training these baby sitters from grades 6, 7, and 8, was begun in 1981. Speakers have included representatives from the Poison Center, the Police Department, the American Heart Association, and a local pediatrician. Mrs. Ronald Fagin compiled the "Baby Sitter's Handbook" which was distributed to all participants.

A total of 65 students have received certificates, and a list of qualified baby sitters has been sent to the schools. Because of the good response from this project, the GEMS clinic will be offered again in the spring of 1983 under the chairmanship of Mrs. James Dewberry.

GLYNN COUNTY members have exemplified the true meaning of caring for each other this year as a result of several deaths and much sickness in their community. They have helped by buying clothes for two boys at Youth Estate, a refuge for youths from troubled homes. They have also continued to participate in the Vial-of-Life program, and were one of the sponsors for the "Feeling Good Health Fair." Another project was collecting magazines for their local hospital and nursing homes.

THE MEDICAL ASSOCIATION OF ATLANTA AUXILIARY has been vitally involved in fund raising for the Restoration of the Academy of Medicine on West Peachtree Street. They have made several donations to the Atlanta Heritage Fund, including a donation from the auxiliary administration of 1981-1982 in the amount of $2,003.38, and from the year 1960-1961 a sum of $1,064.35, which had been held over from that administration. A spring Tour of Homes featuring the work of Philip Trammel Shutze, well-known architect who had designed the Academy of Medicine in 1941, brought in $10,651.48, for a grand total contributed to date by the auxiliary of $13,719.21 to assist in restoring the building.

The Atlanta Auxiliary also gave three scholarships this year to deserving nursing students in the amount of $300 each to help defray expenses of their senior year.

MUSCOGEE COUNTY is continuing their very fine Health Improvement Program in the 4th, 5th, and 6th grades in 11 elementary schools. Students are provided an hour of instruction each day in nutrition or organized physical exercises. They are given 7 screening tests in the Fall with follow-up screening in the Spring to test the benefits of the project. They also donated over 800 Health Record Booklets to the Medical Center for distribution to new mothers.

RICHMOND COUNTY has received much praise for their 2-day Drug Abuse Conference cosponsored by the Auxiliary, the Junior League, and the Office of Continuing Education of Augusta College. Over 500 people were in attendance. Auxiliary members also served as volunteers with the Georgia Lions Eye Bank, and worked with the Highway Safety Board and the American Academy of Pediatrics to present a film "For Jamie" at many local PTA meetings.

SUMTER COUNTY AUXILIARY began in 1979 a project called "Toy Box" at the local hospital by which children scheduled for surgery are provided with toys to help alleviate the fears caused by leaving parents and going into a strange hospital atmosphere. According to Jody Simpson, auxiliary member, "The child is left with a more pleasant



Mrs. James Emory McKinney, of Dalton, President of the Whitfield-Murray Auxiliary (right), and Mrs. Jake Harrison explain some of the activities in their book of projects.

memory of his surgical experience, and parents also are not as apprehensive if the child seems to have something to look forward to when he comes out of anesthesia.''

Another project which has been very successful for the Sumter Auxiliary is their Health Careers Day co-sponsored by the Georgia Southwestern College. This program was originated about 10 years ago by a member who was on the nursing faculty of the school where she saw a need for this project. Beginning in 1973, Dr. James W. Russell, chairman of the biology department at Georgia Southwestern, and the Americus and Sumter County Medical Auxiliary co-sponsored the first biennial Health Careers Day for area high school juniors and seniors. Invited from the community to serve as consultants and to answer questions posed by students seeking information on health careers have been professionals from each of the areas which have interested the participants. On several occasions, representatives have come from area colleges and the state's medical schools.

At each Careers Day, approximately 150 to 200 students have been in attendance, and many counselors, teachers and advisors from the high schools have also participated.

TIFT COUNTY has continued emphasis on combatting Drug Abuse. Members have participated in a Drug Awareness Program in the public schools with Parents In Action. They assisted in a puppet workshop at the Southwest District 4H Rally. Tift Auxiliary was in charge of registration and publicity for the local Health Fair, presented a Burn Prevention program to 3-, 4-, and 5-year-olds in the local nursery schools, and continued their scoliosis screening in grades 5, 7, and 9.

WALKER-CATOOSA-DADE COUNTIES have begun a drug-awareness program and have been responsible for placing in the hands of parents and local school students professional, documented drug information. Members have passed out pamphlets, donor cards, and drug information at every public event they have attended, and have also put infant safety restraint information in new mother packages at the hospital.

WHITFIELD-MURRAY AUXILIARY has a project called ''Hospital Hostesses.'' The members who participate in this program have furnished the Hamilton Memorial Hospital with such services as volunteers to help carry out the annual 6.2-mile Healthcare Classic Road Race; to christen a 20-bed nursing unit, the George L. Rice Pavilion; to dedicate and hold open house for the Lauman Surgical Care Center for outpatient surgery; and to conduct pediatric orientation programs at Hamilton Memorial.

In addition to serving as volunteer hostesses whenever needed, the members of this group have provided clothing for infants, mothers, and emergency room patients to wear when they leave the hospital, and have furnished workers for the Pediatric Ward to entertain children confined to their beds, or to relieve weary parents. Wearing their bright red and white smocks, the members of this auxiliary have become familiar helpers around the hospital.



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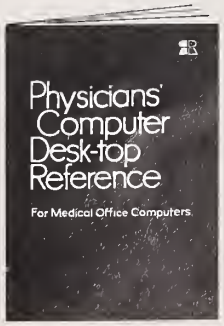
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1. National Interagency Council on Smoking and Health. *The Smoking Diges* Progress Report on a Nation Kicking the Habit. 1977.

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The Public Speaks — Part II

CHARLES W. McDOWELL, JR., M.D., *Decatur,* **and KEN WILLIAMS,** *Atlanta**

THIS IS THE SECOND in this series of articles on the results of the recent public opinion survey on health care issues commissioned by MAG. The poll was conducted at the request of the Public Relations Committee.

The American Medical Association (AMA) commissioned a national survey which was conducted simultaneously with the one here in Georgia. We shall be comparing the views of Georgians with those of Americans nationally.

Since 1972, the AMA has commissioned a series of surveys to measure public attitudes on key health issues. By using some of the findings of these surveys done some 10 years ago, we can clearly identify some trends.

The first question asked of the 406 Georgians interviewed in the poll conducted by the New York-based research organization was, "Now, thinking about everything that has to do with health care, medicine, and doctors, what do you feel is the main problem facing health care and medicine in the United States today?" Sixty-three percent said costs.

Georgians' answer to this question is one percentage point higher than the national sampling. Looking at which segments of the population voice costs as the greatest concern, 79% of the elderly view costs as their number one concern. Interestingly, lower concern over costs is expressed by nonwhites (52%) and cost responses tend to *increase* as education and income go up. Access-related issues are given twice as often by nonwhites as by white respondents.

We have assessed public opinion concerning the amounts of social resources being directed to various sectors of the economy, i.e., education, defense, health care, financial assistance for the needy, public transportation, and protecting the environment. Although in the previous question, 63% said costs is the number one problem, 50% of Georgians say we do not, as a society, spend enough on health care (Table 1).

A total of 50% say we don't spend enough on health care, 32% say we spend about the right amount on health care, and only 16% say we spend too much. In Georgia, nonwhites, by a 69% majority, say we spend too little on health care. Georgia's 50% response is higher than any of her surrounding neighbor states.

Responsibility for Rising Health Care Costs

Our survey results indicate that the public is confused over who is to blame or responsible for the rising costs of health and medical care. Much of the public's perceptions on the cost issue are shaped almost totally by the media. Much of this "information" consists of charges and countercharges made by the various groups as to who exactly is responsible for the cost "crises."

We asked the question, "Thinking about the rising costs of health care, do you think . . . deserve a lot, some, or not much of the responsibility for rising health care costs?" We have ranked their answers in the order the public gave in each category below. For example, in the "a lot" column, the public rated hospitals as the number one group who should be "blamed" for a lot of the responsibility for rising health care costs (Table 2).

The most useful data are found in the "not much" category. The bottom line is that four out of five Americans blame every group in this list for rising health care costs. While hospitals, physicians, and drug companies run one, two, and three, respective-

* Dr. McDowell is Chairman of MAG's Public Relations Committee and practices ophthalmology; Mr. Williams is Director of Public and Professional Relations for the MAG. Send reprint requests to Mr. Williams at 938 Peachtree St., NE, Atlanta, GA 30309.

TABLE 1 — Response of Georgians to the question, "Let's think about the way our society spends money on various problems. Do you think we as a society are spending too much money, about the right amount, or not enough money on . . . (the following items) . . .

	% who said "too much"	% who said "about the right amount"	% who said "not enough"
Defense	32	32	31
Public Transportation	26	44	26
Financial Assistance for the Needy	23	26	48
Health Care	16	32	50
Protecting the Environment	13	34	51
Education	9	26	64

ly, most other options are closely bunched just behind. It is clear that the public believes there is a cost problem but is confused and fragmented in terms of who is primarily responsible. This kind of situation causes a potential for "scapegoating" especially if the cost issue becomes more volatile politically.

Results from the Georgia study are very similar to the national findings. In both surveys, the subgroups most likely to blame organized groups such as the AMA were *the elderly and nonwhites*. In contrast, those aged 35-44 and earning $20-30M were most likely to place responsibility on physicians.

Nationally, the public ranks education, the environment, and financial assistance for the needy ahead of health care in terms of the need to spend more money.

Confidence in Ability to Pay Medical Costs

Since 1977, the AMA has evaluated, through surveys, the public's confidence in their ability to pay for both usual medical costs and an extended illness. Here in Georgia, we asked the question, "Generally, how confident are you that you have enough money or health insurance to pay for the usual medical costs that a family requires: very confident, fairly confident, not too confident, or not at all confident?"

The results are as follows: 33% were very confident, 40% were fairly confident, 15% were not too confident, and 12% were not at all confident.

We asked the same question *except* we substituted "a major illness" instead of asking about "usual medical costs." As might be expected, the confidence figures drop, and the not-confident figures increase. The results were: 25% were very confident that they could pay for a major illness; 36% are fairly confident; 20% are not too confident; and 20% are not at all confident that they either have enough insurance or money to pay for a major illness.

In summary, 73% of Georgians are confident (either very or fairly) that they could pay for the usual medical costs that a family requires. Sixty-one percent are confident (either very or fairly) that they could pay for a major illness. Georgians are slightly more confident in both categories than the nation as a whole.

Interestingly, back in 1978, only 50% expressed confidence that they could pay for a major illness. These are national figures. That figure nationally has increased to 59%. This increase is unexpected because of current high levels of unemployment in a recessionary economy. One possible explanation lies in the fact that a solid public majority has in recent years expressed a desire to increase their health insurance coverage. It may be that greater coverage is giving people more confidence in their ability to pay for health care.

If costs continue to rise at a rate comparable to the rate of increase experienced in the last 10 years, the public's respect for physicians and other providers will surely lessen. Although physicians continue to be near the top of those most respected, our public opinion survey shows that 62% of those asked agree with the statement, "People are beginning to lose faith in doctors."

We can all cite the major reasons why medical costs have dramatically increased:

Inflation — Salaries, supplies, utilities, rent, etc.

Insurance Coverage — As direct out-of-pocket payments decrease, so does cost consciousness on the quantity and quality of care consumed. As insurance coverage of the population increases, the quantity and quality of care demanded also increase.

Age Distribution — As our population ages, medical and health care costs escalate.

Growth and Technology — Today's patients demand and deserve the best equipment and facilities available. We have entered the era of the artificial heart, computed tomography, ultrasound, fetal monitoring, laser beams, and nuclear radiology.

Defensive Medicine — The threat of medical liability suits and some of the staggering awards of late have astronomically increased liability insurance. Physicians now, more than ever, confirm and reconfirm their diagnosis or treatment of a medical problem. We order more lab tests, more X-rays, more office visits, second and third opinions, and so on, to corroborate that we are provid-

TABLE 2 — Response of Georgians to the question, "Thinking about the rising costs of health care, do you think . . . deserve a lot, some, or not much of the responsibility for rising health care costs?"

A Lot	*Some*	*Not Much*
Hospitals	Organized groups such as the AMA	Patients who seek unnecessary care
Doctors	Drug Companies	People who don't pay enough attention to preventive health care or who have unhealthy personal habits
Insurance Companies	Government agencies that set and enforce health care standards	Unions
Drug Companies	Doctors	Organized groups such as the AMA
Patients who seek unnecessary care	Unions	Insurance Companies
People who don't pay enough attention to preventive health care or who have unhealthy personal habits	Hospitals	Government agencies that set and enforce health care standards
Government agencies that set and enforce health care standards	Insurance Companies	Drug Companies
Organized groups such as the AMA	Patients who seek unnecessary care	Doctors
Unions	People who don't pay enough attention to preventive health care or who have unhealthy personal habits	Hospitals

ing proper care for our patients.

Government Regulation — Some estimates indicate that as much as 25% of total hospital expenditures are caused by governmental regulations. Each of us can determine how such regulations have affected our practice.

Utilization and Overutilization — In 1973 (before the U.S. Government began paying for dialysis), the cost to the government was zero. In 1981, the cost to the government for dialysis treatment is estimated to be $1 billion. We are saving and prolonging lives of patients today who would not have lived only a few years ago.

Lifestyles — As Americans, many of us smoke, eat too much, exercise too little, drink to excess, abuse our bodies with drugs, get too little sleep, and live very stressful lives. Some statisticians claim that we could cut our medical bill in half by eliminating our "less-healthy" habits.

What Can Be Done?

There are a number of things that we as physicians can do. We would call to your attention a brochure printed by the MAG, "Why Medical Costs Have Increased and What Can Be Done About It." The brochures are available for your office use at $25 per 100. Below are some suggestions listed therein:

Beware of patient hospital costs and ancillary charges.

Discourage use of emergency room facilities as outpatient, non-emergency care centers.

Admit patients to hospitals when necessary, with insurance coverage not a determining factor.

Order laboratory and radiology tests not only with deliberation but, when necessary, with consultations with pathologists and radiologists. Never order studies at the request or whim of the patient unless medically indicated for quality care.

Initially order drugs in limited quantities until efficacy of the drug is established.

Discharge patients on the basis of optimum care with consideration of daily hospital discharge time.

Do not discharge patients at the patient's convenience or be coerced by family to keep the patient hospitalized.

Admit patients to coincide with usual hospital day charges and not late in the week if the patient will not benefit from Saturday/Sunday hospitalization.

Make every effort to shorten a patient's hospital stay without sacrificing quality of medical care, and when possible, use extended care facilities.

When admitting patients, have a coordinated plan of action to assure diagnostic workups without delay. Ancillary departments can be consulted to help coordinate the action plans.

Your MAG for some time has been a part of what has become known as the "Voluntary Effort." This group, composed of associations and businesses, is an example of medicine and the business community joining hands in attempting to slow the growth in the health care cost spiral.

The MAG has become a part of the Greater Atlanta Coalition of Health Care, Inc. This is another of

our attempts to join with others in taking a close look at anything that can be done toward containing costs.

Our first concern is and shall continue to be top quality care. We must, however, keep in mind the costs of the care we provide. Should we not, the alternatives may be far worse than any of us imagine.

In Summary

Physicians continue to be respected by the public about as well as any professional group.

The public has begun to lose faith in doctors.

If medical and health care costs continue to escalate as they have, our envied position will diminish.

We must decide what priority we give to our public relations efforts.

The decision is yours and mine.

We can make a difference!

Next month, we shall focus on how the public views physicians, i.e., our fees, satisfaction with the latest visit to a physician's office, how we are selected, the decision to retain our services, and "our image."

Following this series, reprints of the survey results (all 35 pages) may be obtained by contacting: Mr. Ken Williams, Medical Association of Georgia, 938 Peachtree Street, NE, Atlanta, GA 30309.

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Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

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Adult Chemical Dependency

The Adult Chemical Dependency Program offers a unique and innovative treatment modality that includes inpatient treatment and an emphasis on aftercare. The staff views alcohol and drug dependency as a primary disease that affects a person physically and psychologically.

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The Adult Psychiatric Program at Ridgeview provides specialized treatment for persons suffering from depression, anxiety, schizophrenia, manic-depressive disorders, personality disorders, and other similar dysfunctions.

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Adolescent Treatment Services

The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

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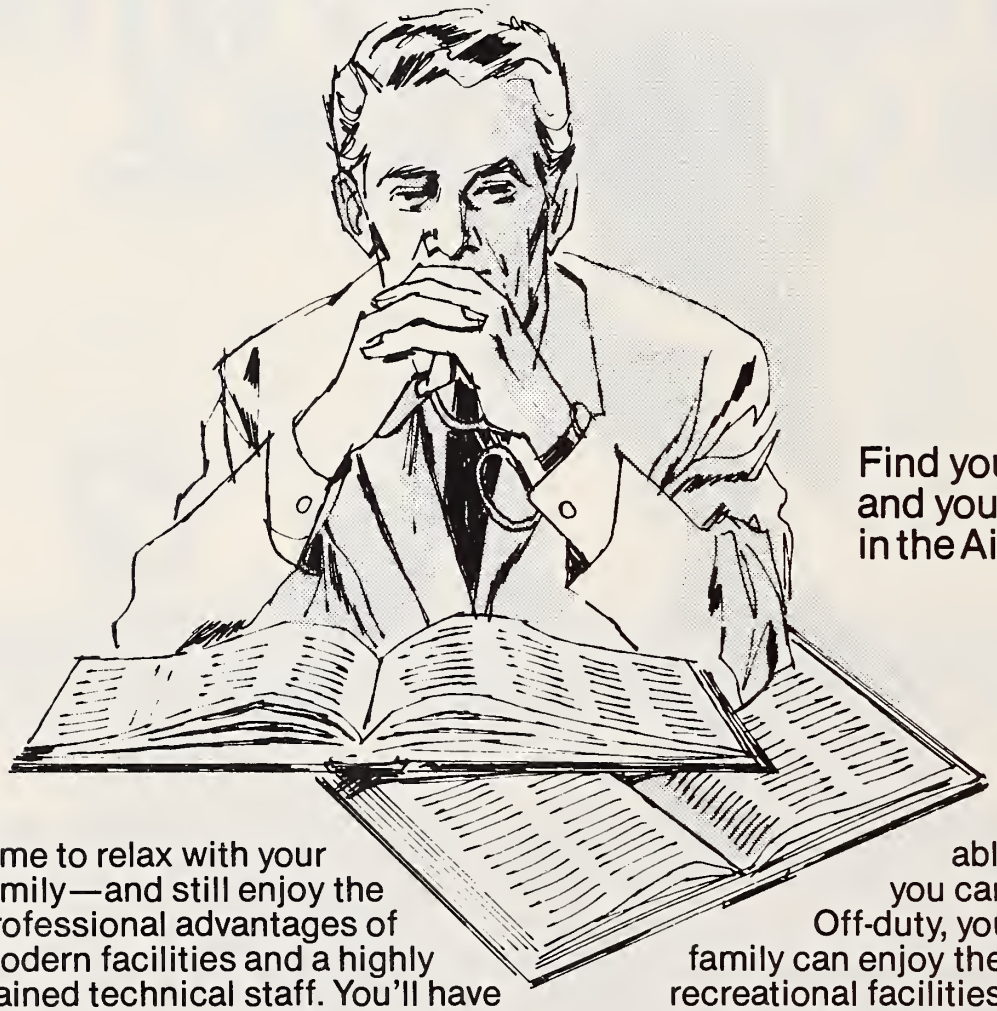
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AIR FORCE

Thrombolytic Therapy in the Management of Venous Thromboembolism

NANETTE K. WENGER, M.D., *Atlanta**

THE ADVANTAGES of thrombolytic therapy with urokinase and streptokinase as compared with conventional anticoagulant drugs in the management of the more severe forms of venous thromboembolism have been documented in controlled clinical trials. Their safety has been established. In patients with extensive deep-vein thrombophlebitis, thrombolytic therapy increases the rapidity of clinical improvement and significantly reduces the likelihood of subsequent venous valve dysfunction of the leg and the development of the post-phlebitic insufficiency syndrome. For the critically ill patient with massive pulmonary embolism and sustained hypotension or clinical shock, thrombolytic therapy is an attractive alternative to pulmonary embolectomy. Even for patients with massive pulmonary embolism and acute cor pulmonale without clinical shock, the results with thrombolytic agents are better than those obtained with conventional anticoagulant therapy.

Both streptokinase and urokinase convert plasminogen to plasmin. Urokinase is a direct plasminogen activator; streptokinase first binds to plasminogen and the SK-plasminogen activator complex converts plasminogen to plasmin.

Conventional anticoagulation with heparin or coumadin for patients with venous thromboembolism decreases or prevents propagation of deep-vein thrombosis and decreases or prevents recurrent pulmonary embolism. However, anticoagulant therapy does not eliminate the source of the pulmonary emboli, does not rapidly change the hemodynamic disturbances in the veins of the leg or in the lungs, does not prevent damage to the venous valves in the deep veins of the leg as the clot organizes and the resultant venous hypertension, and does not prevent compromise of the pulmonary vascular bed with resultant pulmonary hypertension. The body's intrinsic lytic system gradually, but at times incompletely, lyses existing thromboemboli. Recanalization and organization of the residual thrombus help restore vascular patency. The advantage of thrombolytic therapy is that lysis, both of the thrombi and of the emboli, can more rapidly restore normal circulation and thereby normalize the hemodynamic alterations. However, to attain an optimal benefit: risk ratio with thrombolytic therapy, four factors seem important: first, the establishment of a firm diagnosis; second, the documentation that the venous thromboembolism is of sufficient severity to warrant thrombolytic therapy; third, attempting to minimize the risk of bleeding by careful patient selection, by obtaining appropriate baseline data, by avoiding or keeping to a minimum invasive procedures before and

* Dr. Wenger is Professor of Medicine (Cardiology), Emory University School of Medicine, and Director, Cardiac Clinics, Grady Memorial Hospital, Atlanta. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

during thrombolytic therapy, and by appropriate surveillance and monitoring during therapy; and fourth, instituting conventional anticoagulation after the completion of thrombolytic therapy.

Absolute contraindications to the use of thrombolytic therapy include active or recent bleeding, particularly of gastrointestinal or genitourinary origin; and recent (within 2 months) cerebrovascular accident or intracranial disease. Recent (less than 10 days) major surgery, delivery, biopsy, or invasive procedures; recent serious internal bleeding; major trauma; and severe uncontrolled hypertension are important relative contraindications. Also of concern are recent cardiopulmonary resuscitation, recent minor trauma, infective endocarditis, high likelihood of a left-heart thrombus as in the patient with mitral valve disease and atrial fibrillation, pregnancy, known hemostatic defects including those associated with severe renal or hepatic disease, diabetic hemorrhagic retinopathy, and the elderly patient. In recent years, the availability of intravenous sodium nitroprusside therapy to rapidly control excessive levels of blood pressure has minimized this latter problem.

A firm diagnosis of deep-vein thrombosis is best made by isotope or contrast venography; and that of pulmonary embolism either by pulmonary angiography or with a combination of radioisotope lung scanning and isotope venography. Thrombolytic therapy is most effective for a thrombus or embolus of recent origin, preferably less than 5-7 days old (based on the clinical history of recent symptoms). After 7 to 10 days, collagen and fibroblasts progressively replace the fibrin of the thrombus so that thrombolysis is not feasible. Currently, patients with proximal deep-vein thrombosis, i.e., major obstruction of the iliofemoral system, and massive pulmonary embolism, that with a large percentage of obstruction of the pulmonary vascular bed or with associated hemodynamic compromise, are considered optimal candidates for thrombolytic therapy.

As bleeding is the major risk of therapy, the proper selection of patients, their surveillance, and the avoidance of invasive procedures are requisite to minimize this risk.

Normal baseline laboratory data: hemoglobin and hematocrit, platelet count, prothrombin time, and thrombin time or activated partial thromboplastin time — assure that the patient does not have a serious hemostatic defect that might increase the risk of bleeding. Stool guaiac determination should be negative; a blood sample should be obtained for typing and cross-match. Heparin therapy should be discontinued to allow the thrombin time or activated partial thromboplastin time to return to within two times the control value prior to the institution of thrombolytic therapy; for this reason, administration of a large bolus dose (''loading dose'') of heparin is unwise for patients for whom thrombolytic therapy is being considered. Placement of a Swan-Ganz catheter via the jugular and subclavian approaches should be avoided, as should the use of the femoral artery to obtain an arterial sample for blood gas determination or to perform a pulmonary angiogram. Arm vessels should be used for these procedures as their use permits direct pressure hemostasis. Thoracentesis should be deferred. Intramuscular injections should be avoided.

The patient should be at bed rest during thrombolytic therapy, which is best administered in an intensive care setting; invasive procedures should be avoided, and pressure dressings used on any invasive site. Use of a sandbag provides effective pressure hemostasis and enables inspection of the site. A heparin lock should be inserted prior to instituting thrombolytic therapy and used for administering medications and obtaining blood samples. Vital signs should be checked frequently. Aspirin and any other antihemostatic drugs cannot be used concurrently with thrombolytic agents.

Thrombolytic therapy must be reconstituted according to the manufacturer's directions and administered intravenously, using a constant infusion pump, with

the drug diluted as per the package insert. For streptokinase, the loading dose is 250,000 units administered over a 30-minute period; the maintenance infusion of 100,000 units per hour is given for 24-72 hours. Urokinase therapy requires a loading dose of 2,000 units per pound of body weight, administered over a 10-minute period, followed by a maintenance infusion of 2,000 units per pound of body weight per hour, administered for 12-24 hours.

At about 3-4 hours after beginning the infusion of streptokinase or urokinase, the hemoglobin or hematocrit should be rechecked to assess for occult bleeding, as should the thrombin time or activated partial thromboplastin time to insure that fibrinolysis has been achieved. Serial measurements of the level of fibrinolytic activity are unnecessary, as they correlate poorly with success in thrombolysis.

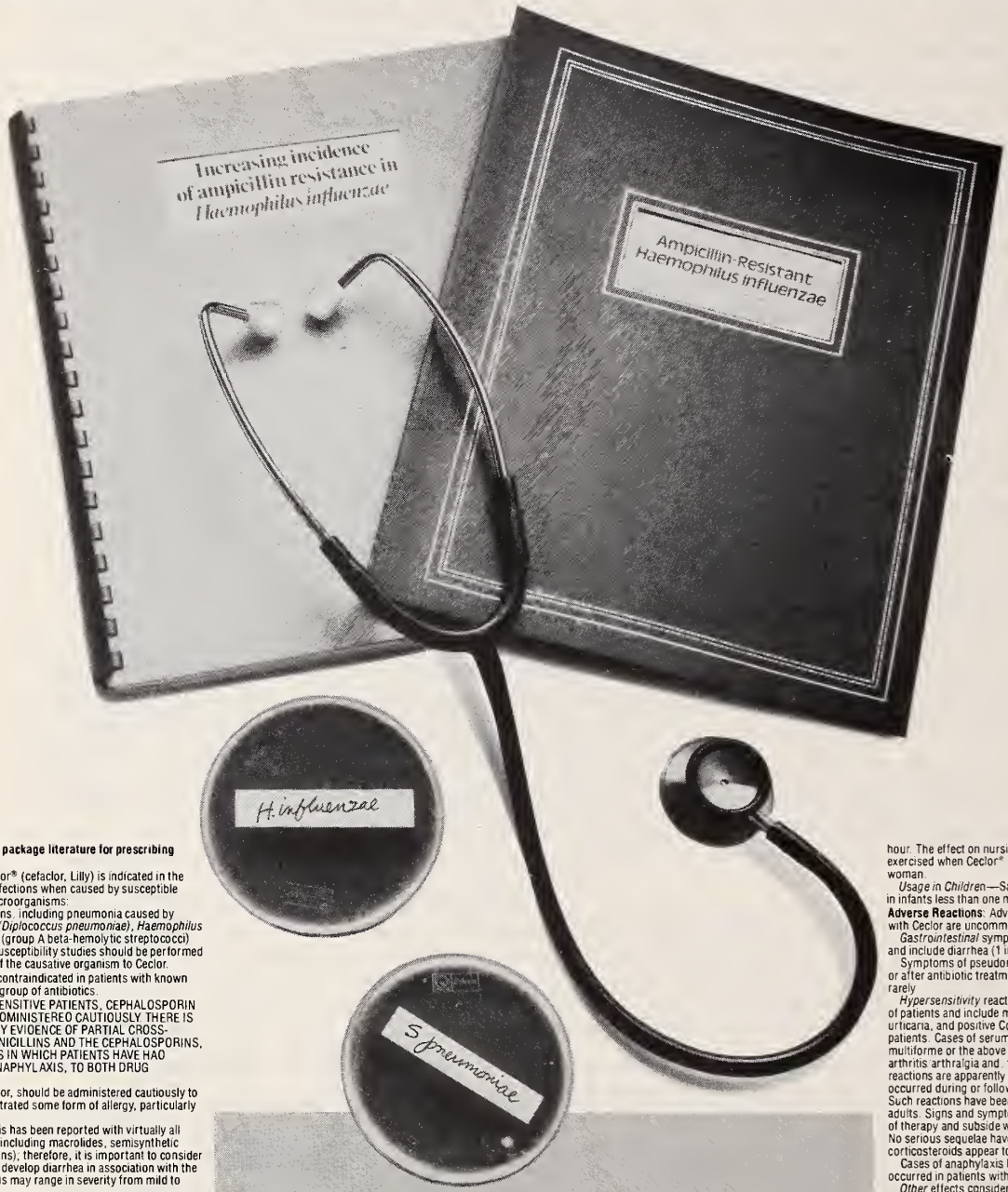
The effectiveness of urokinase or streptokinase is dependent on their ability to lyse the fibrin clot. This makes bleeding the major risk of the therapy. Proper selection of patients, their surveillance, and the avoidance of invasive procedures minimize the risk of bleeding. Extensive capillary oozing is the most common form of bleeding. Should bleeding occur, the infusion should be discontinued, firm pressure applied to the bleeding site when feasible, and transfusion of fresh whole blood given; fresh frozen plasma or cryoprecipitate can also reverse the coagulation defect. The use of a specific plasma inhibitor such as epsilon amino caproic acid is rarely needed. Allergic and febrile reactions are usually mild, do not generally require the discontinuation of thrombolytic therapy, and respond to antihistamine, acetaminophen or corticosteroid administration.

The thrombin time or activated partial thromboplastin time should be within two times the control level, which generally occurs at 3-5 hours after cessation of thrombolytic therapy, before heparin anticoagulation in standard doses is reinstituted. A loading dose of heparin should be avoided, as a partial thrombolytic state is still present. Typically, 7 to 10 days of heparin therapy are followed by coumadin anticoagulation; this helps avert recurrent thrombosis until endothelial repair is effected at the site of the original thrombus.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 2 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. The reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 10 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Current Concepts in the Diagnosis and Management of Brain Metastasis

DAVID B. KEE, JR., M.D., and JAMES H. WOOD, M.D., *Atlanta**

BRAIN METASTASIS from systemic malignancy presents common and often difficult diagnostic and therapeutic dilemmas for physicians. Approximately one out of every five cancer patients is found to have intracranial metastases at autopsy.[1] Although the number of these intracranial tumor deposits detected clinically is only 65 to 75%,[13] the clinical incidence of brain metastasis will approach that of autopsy series as newer treatment modalities improve the length of survival of cancer patients. Therefore, the screening, diagnosis, and appropriate management of brain metastases are vital to all physicians who treat patients at risk for cancer.

Patient Evaluation

Certain malignancies have well known predilection for intracranial metastasis. Lung, breast, kidney, and gastrointestinal cancers comprise the majority of metastatic brain tumors.[2, 5, 11] Malignant melanoma, while of lower incidence, has the greatest propensity of any cancer to metastasize to the brain.[2] The occurrence of headache, focal neurologic deficit, or seizures in a patient known to have one of these cancers should immediately raise the possibility of central nervous system metastasis. A careful search for papilledema, hemiparesis (which may be quite subtle), visual field loss, or any impairment of cognitive function will often yield findings suggesting the presence of an intracranial tumor and the urgent need for further evaluation.

For patients with probable brain metastasis, physicians must formulate a diagnostic workup which will provide maximal information while minimizing patient discomfort and expense. Complicating this process is the fact that 30-50% of patients present with brain metastasis as the first manifestation of their underlying malignancy.[2, 11] Therefore, a reasonable diagnostic approach to both the primary and metastatic tumor is needed. Voorhies and coworkers[17] have demonstrated that, in the absence of a history of known cancer, a plain chest radiograph and an intravenous pyelogram are the only studies likely to yield the primary source of tumor. If these two studies prove negative, further diagnostic evaluation is unrewarding, time consuming, and expensive. In 20% of patients with brain metastasis, no primary tumor is ever found during the lifetime of the patient.[8]

Currently, the vast array of neurodiagnostic studies available to the physician includes skull radiography, electroencephalography (EEG), radionuclide scanning, computed tomographic (CT) scanning, lumbar puncture, pneumoencephalography, and cerebral arteriography, all of which have been used to demonstrate

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Prepared at the request of the Georgia Division, American Cancer Society.

the presence of intracranial mass lesions. Skull radiography and lumbar puncture are not definitive, do not have localizing value, and, in the case of lumbar puncture, is potentially fatal to patients harboring brain tumors. Pneumoencephalography has little place in modern practice and EEG, although non-invasive and often localizing, has been largely replaced by CT scanning. Radionuclide brain scanning, previously the procedure of choice, has recently also been supplanted by CT scanning in the detection of intracranial metastases. A recent study suggests that radionuclide and CT scanning are complimentary in the evaluation of brain metastasis.[7] However, the current availability of third and fourth generation CT scanners, with a resolution of less than one centimeter,[3] has challenged the utility of radionuclide scanning in this patient population. Cerebral arteriography, while no longer a first-line procedure for the diagnosis of brain tumor, may still provide useful information for surgical management in selected cases.

Currently, the Emory Metastatic Brain Tumor Protocol is evaluating the sensitivity and specificity of contrast-enhanced high-resolution delayed CT scanning in the detection of single and multiple brain metastases. Our high-resolution CT scanner will detect lesions as small as 0.6 centimeter in diameter.[3] Contrast agents, used in double dosage, cross the disrupted blood-brain barrier surrounding metastatic tumor deposits and enhance the resolution of the computed image. Since steroid therapy decreases the edema and disruption of the blood-brain barrier surrounding metastatic tumor,[6] every attempt is made to obtain the double-dose delayed scan prior to the initiation of steroid therapy. The delayed-scanning technique offers two advantages over immediate conventional scanning. First, a single lesion which is missed on the immediate scan may be demonstrated on the delayed scan when a sufficient quantity of contrast medium has crossed the blood-brain barrier. Secondly, multiple metastases are more apt to become apparent on delayed scans, thus potentially altering patient management. Examples of this technique are shown in Figures 1 and 2.

Treatment

The current therapeutic approaches to the patient with brain metastasis are designed to permit the best possible quality of life during what is usually a limited time of survival. The mean survival from the time of diagnosis in cases of untreated brain metastasis is approximately 3 months.[9, 11] Chemotherapy, radiation therapy, and surgery have been investigated with regard to their potential to alter the natural course of the disease.[2, 4, 8, 9, 11-14] In addition, steroids and anticonvulsants are widely accepted as useful adjuncts in the management of tumor-related cerebral edema and seizures, respectively. At present, there is no convincing evidence (with the exception of metastatic choriocarcinoma[13] and oat cell carcinoma[7]) that chemotherapy, either alone or in combination with other modalities, has a significant effect on the quality or duration of survival in these patients. Radiation therapy has proven to be effective in the palliation of brain metastases by increasing mean survival to 3-6 months and has been reported to sterilize metastatic tumor deposits in a very small percentage of patients.[4] Whole brain radiation therapy is felt to be the treatment of choice in patients with multiple metastases.[2, 8, 13] The exception to this rule occurs in the patient with multiple metastases who develops life-threatening brain stem compression secondary to tumor or the attendant cerebral edema and hydrocephalus. These patients are considered candidates for emergency surgery if not in the terminal stages of their disease. This is particularly true of cerebellar metastasis, in which surgical decompression of the posterior fossa is often associated with dramatic improvement. Many of these patients are in deep coma preoperatively but have normal or near-normal neurologic function after surgery. In addition, all patients with multiple brain metastases are candidates for CT-directed needle biopsy, under local anesthesia, of an accessible brain lesion. Biopsy is of greatest importance if no tissue diagnosis of a primary tumor has been made, since obtaining tissue in this manner will allow appropriate evaluation of candidates for radiation therapy and/or possible chemotherapy.

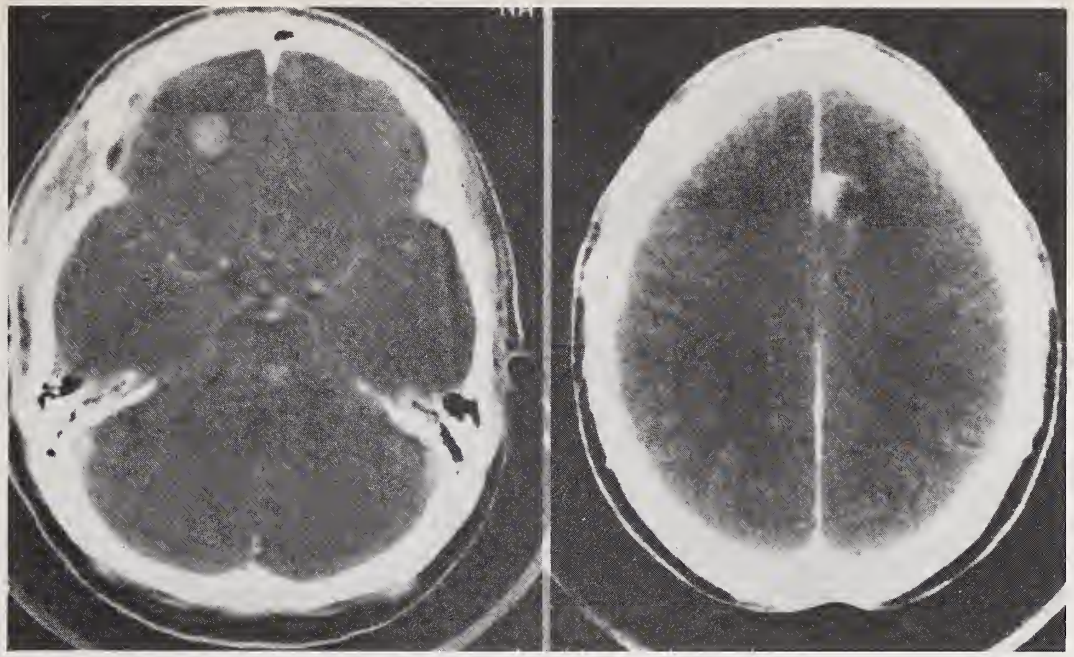


Figure 1 — Delayed computed tomographic scan of patient with metastatic malignant melanoma following double-dose intravenous contrast injection. Note multiple enhancing lesions in both frontal lobes and brainstem. Midbrain tumor deposit (left) measures approximately 8 mm.

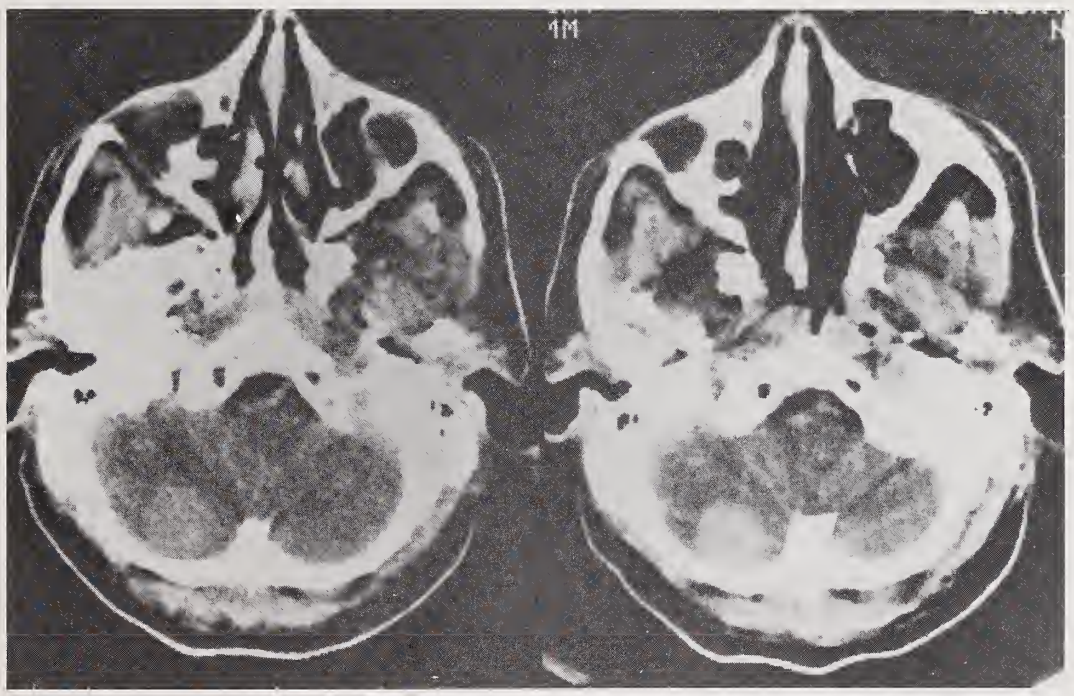


Figure 2 — Immediate and delayed computed tomographic scans of patient with right cerebellar metastasis from squamous cell carcinoma of lung. Immediate scan (left) reveals lesion in cerebellar hemisphere which becomes more clearly defined with delayed scan (right) and improved contrast enhancement.

A question being addressed by the Emory Metastatic Brain Tumor Protocol with respect to certain types of cancer such as melanoma is whether whole brain radiation should be performed as a prophylactic measure at the time of primary tumor resection before the CT detection of brain metastasis, or should radiation be held until the brain lesions are demonstrated. Potentially, tumor antigens, factors, or enzymes detected in centrally isolated cerebrospinal fluid[15] could help define a subgroup of patients in whom central seeding of tumor has already occurred at the time of primary tumor detection. Identification of this high-risk population would enable the evaluation of "prophylactic" neuraxis radiation at a time when the tumor burden is minimal.

The approach to patients with a single brain metastasis has received much attention in recent years.[5, 11, 14, 17] While some authors suggest that no treatment

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Table I — Surgical Management of Patients with Brain Metastasis

- **I. Single Brain Lesion**
 - **A. Patient criteria for craniotomy and tumor excision**
 - **1. No medical contraindications to craniotomy**
 - **2. Projected survival of 3 months or longer**
 - **3. Tumor location compatible with total or subtotal excision**
 - **B. Patient criteria for CT-directed needle biopsy**
 - **1. Medical contraindications to craniotomy**
 - **2. Life expectancy less than 3 months**
 - **3. Lesion located in vital brain structure**
 - **4. Potential candidate for radiation and/or chemotherapy**
 - **5. Need for tissue diagnosis**
 - **C. Patient criteria for cerebrospinal fluid shunting**
 - **1. Presence of hydrocephalus**
 - **2. Nonterminal systemic disease**
- **II. Multiple Brain Lesions**
 - **A. Patient criteria for craniotomy and tumor excision**
 - **1. Life-threatening brainstem compression in nonterminal, medically-stable patient**
 - **B. Patient criteria for CT-directed needle biopsy**
 - **1. Potential candidate for radiation and/or chemotherapy**
 - **2. Need for tissue diagnosis**
 - **C. Patient criteria for cerebrospinal fluid shunting**
 - **1. Presence of hydrocephalus**
 - **2. Nonterminal systemic disease**

modality has significant advantage over another in the management of solitary cerebral metastasis,[12] much convincing evidence supports an aggressive combination of surgical and radiation therapy for these patients.[2, 5, 8, 9, 10, 14, 17] Since the development and refinement of cranial CT, the median survival of patients undergoing craniotomy for brain metastasis has improved from a pre-CT median of 6 months to a current median of 12 months.[5] In all published series, the only long-term (greater than 5 years) survivors were those patients who underwent surgical excision of their metastasis with or without postoperative irradiation.

According to our Protocol, all patients found to have brain metastasis are evaluated for potential surgical therapy as outlined in Table I. The majority of our patients experience postoperative quality and duration of survival that compares favorably with recently published series.[2, 5, 8, 11, 13, 17]

Presently, all patients with brain metastasis undergo radiation therapy.[2, 5, 9] However, no data are available concerning the efficacy of whole brain radiation therapy following the gross total excision of a single brain metastasis. This therapeutic approach is based on two assumptions. First, the detection of a single metastasis implies the presence of multiple, yet-undetected microscopic metastatic deposits in the brain. Second, radiation therapy will impede or prevent recurrence of the gross-totally excised metastasis at the operative site. Perhaps radiation therapy should be delayed until tumor recurrences become apparent. Clinical protocols are currently being formulated at our institution which will attempt to evaluate the timing of radiation therapy following excision of a single metastasis.

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Applying Georgia's Medical Malpractice Statute of Limitations in "Foreign Object" Cases

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In theory, a statute of limitations is a simple concept: a plaintiff must file a lawsuit within a fixed period of time; failure by the plaintiff to do so bars the plaintiff forever from filing the lawsuit. In practice, however, application of this simple concept has been anything *but* simple. Taking one example, courts on numerous occasions have struggled with the question of *when* the statute of limitations begins to run — From the date of the wrongful act? From the date of the injury (which may or may not be contemporaneous with the date of the wrongful act)? From the date on which the plaintiff discovered or should have discovered the existence of the wrongful act? In the context of medical malpractice lawsuits, the interests of physicians may be significantly affected depending upon which of these commencement dates is used: If the date of the alleged wrongful act starts the statute of limitations, the physician need only be concerned with the institution of a malpractice lawsuit arising out of that act for a fixed period of time (e.g., 2 years); however, if the statute of limitations starts only after the patient discovers the existence of the wrongful act, the physician may — and oftentimes is — sued for malpractice many years after the alleged wrongful act was completed.

As a result of the complexities involved in applying one statute of limitations to the numerous types of different lawsuits which may be filed, most states have enacted a number of different statutes of limitations, which may or may not be applicable depending upon the particular type of lawsuit involved. In particular, many states, including Georgia, have enacted special statutes of limitations applicable in medical malpractice actions. Furthermore, most of these special statutes distinguish between two types of medical malpractice actions: a "general" statute of limitations governing most types of medical malpractice actions; and, a "special" statute of limitations applicable where a "foreign object" has been left in a patient's body.

Georgia's version of this "special" statute of limitations recently was the subject of an interesting decision by the Georgia Court of Appeals.

Historical Background of Georgia's Medical Malpractice Statute of Limitations

Prior to 1971, medical malpractice actions in Georgia were not distinguished from other types of actions for injuries. As a result, a medical malpractice action was required to be instituted within 2 years of the date on which the plaintiff's right

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of action "accrued."[1] This, in turn, was interpreted by Georgia courts as requiring that the malpractice action be brought within 2 years of the occurrence of the negligent or wrongful act.[2]

Although use of Georgia's 2-year statute of limitations offered the obvious benefit of providing a "hard and fast" rule capable of being easily understood by prospective plaintiffs and easily applied by Georgia courts, application of this statute of limitations in practice oftentimes worked severe and unfair hardships upon persons injured by negligent or wrongful acts. For example, in cases involving medical malpractice, the patient, as a result of the particular acts of negligence, sometimes legitimately could not have discovered the existence of the negligent or wrongful act until after the running of the 2-year period; nonetheless, the patient was barred from filing the malpractice action because the statute of limitations had expired.

In order to alleviate this unfairness, the Georgia Court of Appeals, in a 1971 landmark decision,[3] applied the "continuing tort" doctrine in order to allow a plaintiff to circumvent the 2-year statute of limitations and institute a lawsuit against a physician for negligently leaving a clamp in the patient's body. In the Court's view, while the negligent act *commenced* on the date in which the clamp was left in the patient's body, the wrongful act continued as long as the clamp remained. Thus, the Court determined that the 2-year statute of limitations could only start to run from the time at which the patient discovered, or through the exercise of ordinary care should have discovered, the existence of the "continuing tort."

Subsequently, the Court of Appeals expanded the concept of "continuing tort" to cover not only cases involving the leaving of a foreign object in the patient's body, but virtually to all types of medical malpractice cases.[4] In doing so, the Court determined that the injury resulting from an act constituting medical malpractice oftentimes was not immediately apparent, such that "the statute of limitations [should be] tolled so long as the victim could not in the exercise of ordinary care have learned of it."

Since the application of the simple concept in this statute has been anything* but *simple, many states, including Georgia, have enacted special statutes of limitations applicable in medical malpractice.

The expansive interpretations of Georgia's general statute of limitations rendered by courts in medical malpractice actions came to an abrupt halt in 1976, however, when the Georgia General Assembly enacted a new Code Chapter specifically applicable to actions for medical malpractice.[5] In fact, the General Assembly created two new statutes of limitations: (a) a "general" statute of limitations applicable to most medical malpractice actions, pursuant to which "an action for medical malpractice shall be brought within 2 years after the date on which the negligent or wrongful act or omission occurred,"[6] (the "General Malpractice Statute"); and (b) a "special" statute of limitations applicable in "foreign object" cases, pursuant to which "(t)he 2-year limitation [in the General Malpractice Statute] shall not apply where a foreign object has been left in a patient's body, but in such a case an action shall be brought within 1 year after the negligent or wrongful act or omission is discovered,"[7] (the "Foreign Object Statute").

Medical malpractice plaintiffs quickly challenged the constitutionality of the medical malpractice statute. These challenges were unsuccessful, however, as the Georgia courts determined that the distinctions made by the Georgia General Assembly — in effect, treating medical malpractice plaintiffs differently from other plaintiffs, and also treating situations involving the leaving of foreign objects in a patient's body differently from other acts constituting medical malpractice —

had a rational basis and bore a substantial relationship to the governmental interest sought to be protected by the General Assembly.

In particular, Georgia courts accepted the legislative rationale for distinguishing between general medical malpractice cases and "foreign object" cases. As cogently summarized by one Court:

> "Where a physician places a foreign object in his patient's body during treatment, he has actual knowledge of its presence. His failure to remove it goes beyond ordinary negligence so as to be classified by the legislature as a continuing tort which tolls the statute of limitations until the object is discovered. The purpose of the legislature in making a distinction between the two types of medical malpractice was to allow the plaintiff's claim which does not rest on professional diagnostic judgment or discretion to survive until actual discovery of the wrongdoing. In such situations the danger of belated, false or frivolous claims is eliminated. The foreign object in the patient's body is directly traceable to the doctor's malfeasance."[8]

While the legislatively created distinction between the General Malpractice Statute and the Foreign Object Statute passed constitutional muster, that distinction also created a new set of interpretative problems for the courts: what constitutes a "foreign object"? In fact, the General Assembly had foreseen this problem and attempted to provide some guidance in the statutory provision itself, stating that "the term 'foreign object' shall not include a chemical compound, fixation device, or prosthetic aid or device."[9] Even this definition, however, created a number of problems necessitating further judicial interpretation.

What Constitutes a "Foreign Object"?

The first cases decided under the Foreign Object Statute presented relatively simple issues concerning the question of the objects falling within the statutory definition of a "foreign object." In one case, a plaintiff contended that a hospital emergency room physician's failure to remove a piece of metal lodged in the plaintiff's leg as a result of an accident occurring while the plaintiff was cutting wood should be considered under the Foreign Object Statute. While the plaintiff's contention was literally true — the physician had "left a foreign object in the patient's body" — the Court of Appeals disagreed, affirming the trial court's interpretation that the "foreign object" must have been *placed* in the patient's body *during some medical procedure* "in such fashion that the practitioner may be charged with knowledge that the object is lodged there."[10]

In a similar case, a plaintiff cut his hand on a ceramic vase and was treated by a physician who attempted unsuccessfully to remove all of the glass. The plaintiff's contention that the glass constituted a "foreign object" was rejected by the Georgia Supreme Court, which held that the physician's failure to remove the particles of ceramic glass (which were not placed in the patient by the physician) was "much more akin to the ordinary mis-diagnosis and mis-treatment cases" which are covered by the two-year General Malpractice Statute.[11]

Both of these cases were decided without reference to the statutory provision setting out what was not included in the definition of a "foreign object." In a third case, however, the Court of Appeals, faced with a plaintiff's contention that a dentist's allegedly negligent replacement of a bridge in the plaintiff's mouth involved the leaving of a "foreign object," held that a dental bridge was in the nature of a "fixation device or prosthetic aid or device" and, as such, was excluded by statute from consideration as a "foreign object." Moreover, the Court noted that: "where, as here, an object is purposely placed in a body it cannot be said to have been 'left,' which, in the context of the statute, connotes a non-purposeful act."[12]

Recently, the Court of Appeals again was faced with the problem of determining what constituted a "foreign object" within the meaning of the Foreign Object Statute.[13] The facts of the case were as follows: In 1973, the defendant physician

performed a hysterectomy on the plaintiff patient. Following the surgery, the patient experienced certain pains and accompanying symptoms, which persisted until 1977, at which time it was suggested that certain radiologic procedures be pursued; it appeared from the evidentiary record before the Court, however, that no such procedures were ordered or performed. In 1980, the patient consulted a second physician, who performed exploratory surgery upon her and, ultimately, removed her left kidney.

The patient filed suit in January, 1981, contending that the first physician negligently placed and left a suture in her ureter leading to her left kidney during the 1973 hysterectomy, resulting in its blockage and necessitating the subsequent removal of her kidney. However, the trial court granted the defendant physician's motion for dismissal, on the grounds that the General Malpractice Statute had expired in 1975, 2 years after the occurrence of the allegedly negligent act.

On appeal, the Court of Appeals reversed the trial court, holding that the Foreign Object Statute was applicable to the plaintiff's cause of action. In doing so, the Court determined that the suture was not a ''fixation device'' which by statute would be excluded from classification as a ''foreign object.'' Rather, in the Court's view:

> ''Where the plaintiffs have alleged the placement of an internal suture during the course of a surgical procedure in an organ or other tissue not ordinarily involved in that procedure and the defendant physician has presented no evidence that the presence of the suture is the result of proper medical procedure, the suture is a 'foreign object' under [the Foreign Object Statute] and the applicable statute of limitations is '1-year after such negligent or wrongful act or omission is discovered.' '' (Footnote omitted)[14]

In other words, the Court drew a distinction between the leaving of an appropriately-placed suture (i.e., a suture placed in accordance with recognized medical procedures and techniques), on the one hand, which would constitute a ''fixation device'' and therefore not be classified as a ''foreign object,'' and a suture placed in an organ or other tissue not ordinarily involved in the surgical procedure and not otherwise justifiable as being the result of a proper medical judgment, on the other hand, which would not constitute a ''fixation device'' and therefore be classified as a ''foreign object'' for purposes of determining the applicable statute of limitations. Thus, the plaintiff benefited from the application of the Foreign Object Statute, which allowed her to file her lawsuit within 1 year of her 1980 operation, the date upon which she ''discovered'' the presence of the suture.

Conclusion

In total, it seems clear that the General Assembly's intent in delineating the types of devices which are *not* included in the definition of a ''foreign object'' was to eliminate from that definition tangible objects utilized by physicians in performing surgical procedures. The Court's decision effectuates this legislative intent, to the extent that it affirms the fact that a suture properly left in a patient's body is a ''fixation device'' and, therefore, not within the definition of a ''foreign object.'' As a result, malpractice cases involving allegations of the leaving of a properly-placed suture will be governed by the 2-year General Malpractice Statute, which, in turn, protects physician defendants ''by preventing surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded, and witnesses have disappeared.''[15]

At the same time, however, it appears that the Court, by analyzing the question of what is a ''foreign object'' on the basis of the purpose for which the object is placed in the patient's body, rather than on the basis of the nature of the object itself, has adopted an analysis which is more complex and less objective than an analysis involving nothing other than a determination of the nature of the object itself. As a result, a physician who places what would normally be considered a ''chemical compound, fixation device or prosthetic aid or device'' in a patient will

have the burden in a malpractice case of establishing that the object was placed in the patient on the basis of a proper medical judgment in order to utilize the General Malpractice Statute as a defense.

(Author's Note: Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power either to affirm or to reverse the decision of the Georgia Court of Appeals, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. In the event that the case discussed in this article is appealed and subsequently reversed by the Georgia Supreme Court, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.)

Notes

1. *Ga. Code Ann.* §3-1004 (1975).
2. See, e.g., *Silvertooth v. Shallenberger*, 49 Ga. App. 133 (1934); *Saffold v. Scarborough*, 91 Ga. App. 628 (1955); see, generally, Comment, 33 Mercer L. Rev. 377 (1981).
3. *Parker v. Vaughan*, 124 Ga. App. 300 (1971).
4. *Forgay v. Tucker*, 128 Ga. App. 497 (1973).
5. O.C.G.A. §§9-3-70 *et seq.* (formerly *Ga. Code Ann.* §3-1101 *et seq.*), enacted by Ga. L. 1976, 1363, §1.
6. O.C.G.A. §9-3-71 (formerly *Ga. Code Ann.* §3-1102).
7. O.C.G.A. §9-3-72 (formerly *Ga. Code Ann.* §3-1103).
8. *Dalbey v. Banks*, 245 Ga. 162, 163-164 (1980); see, also, *Allrid v. Emory University*, 249 Ga. 35 (1982).
9. O.C.G.A. §9-3-72.
10. *Clark v. Memorial Hospital of Bainbridge*, 145 Ga. App. 305, 306 (1978).
11. *Dalby v. Banks, supra*, 245 Ga. at 164.
12. *Shannon v. Thornton*, 155 Ga. App. 670 (1980).
13. *Ivey v. Scoggins*, ___ Ga. App. ___ (September 14, 1982).
14. *Id.*, ___ Ga. App. ___.
15. *Allrid v. Emory University, supra*, 249 Ga. at 39, quoting *Order of Railroad Telegraphers v. Railway Exp. Agency*, 321 U.S. 342, 348-349 (1943).

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THIS YEAR MAG has taken the first step toward increasing involvement of the Auxiliary in MAG activities by placing Auxiliary members on key MAG committees. But this is only a beginning.

I have expansive ideas about the potential role of the Auxiliary in supporting MAG in its many projects. To me, it seems that the Auxiliary is a resource for MAG which has been inadequately used.

I believe it would be advantageous for the MAG to develop an annual plan of action for itself — an agenda of goals — and to delegate to the Auxiliary special aspects of the plan for implementation. The Auxiliary can be more effective and visible as it participates at the state level in MAG programs. In essence, what I would like to see is a true partnership between the Auxiliary and the MAG.

This new role for the Auxiliary should not interfere with activities of the local auxiliary in the various communities. It is most appropriate for local chapters to work on specific projects relevant to the needs of its own area.

To increase communication between MAG and the spouses of physicians, it would be beneficial to send key publications of the MAG to the homes, rather than to the offices, so that both spouses would have access to them. This proposal is being studied to see if and how it can be feasibly accomplished.

In the changing world around us, we in medicine need all the help we can muster to cope with our diverse environment. The Auxiliary is too effective a resource for us to relegate it to a secondary role. We in MAG must elevate the Auxiliary into full partnership.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

NEW MEMBERS

Camp, Leah R., Muscogee—ACT—PH
1958 Talbotton Rd. & 8th Ave., Columbus 31904

Connelly, John C., Muscogee—ACT—P
2000 Sixteenth Ave., Columbus 31993

Cooper, Eugene A., Cobb—ACT
Kennestone Hospital, 737 Church St., Marietta 30060

Desai, Prakash V., Douglas—ACT—PD
9293 Hwy. 5 Medical Center, Douglasville 30135

Fountain, Linda M., Muscogee—ACT(N-2)—PD
The Medical Center, Columbus 31994

Gardner, Edward C., Jr., Crawford W. Long—ACT (N-2)—IM
1007 Baxter St., Athens 30606

Hubbard, Charles N., Carroll-Haralson—ACT (N-2)—ORS
148 Clinic Ave., Carrollton 30117

Page, Crockett H., Dougherty—S—GP
NRMC Jax, Albany Branch, Albany 31704

Parker, Edson O., III, Muscogee—S—AN
Dept. of Anesthesiology, Martin Army Hospital, Ft. Benning 31905

Smith, Tyson D., Jr., Newton-Rockdale—ACT—PTH
4171 Tate St., NE, Covington 30209

Udel, Melvin M., Cobb—ACT—P/PM
3985 S. Cobb Dr., Smyrna 30080

Van Dyck, Philip G., Crawford W. Long—ACT (N-1)—R
Athens General Hospital, Athens 30613

Ware, John R., Carroll-Haralson—ACT (N-1)—IM
Carrollton Medical Arts Center, 523 Dixie St., Carrollton 30117

West, J. Michael, Crawford W. Long—ACT (N-2)—GE
1077 Baxter St., Athens 30306

PERSONALS

First District

Edward F. Downing, M.D., and **Fremont P. Wirth, M.D.,** of Savannah, were elected to the executive committee of the Congress of Neurological Surgeons.

Leonard Shpak Wojnowich, M.D., of Savannah, was named a diplomate of the American Board of Family Practice.

Third District

At the November 27, 1982, meeting of the Muscogee County Medical Society, **William C. T. Jernigan, M.D.,** was installed as the new President for 1983. **John S. Newton, M.D.,** was elected President-Elect. **Jack A. Raines, M.D.,** was nominated as Director to MAG and **E. M. Molnar, M.D.,** was nominated Alternate Director. All are from Columbus.

Fourth District

Edwin J. Galler, M.D., of Decatur, was elected chief of the DeKalb General Hospital medical staff for the 1982-83 term. Dr. Galler currently serves as chairman of the medical staff's By-laws and Accreditation Committees and works with the Internal Medicine Peer Review Committee.

Fifth District

Atlanta physician, **James A. Kaufmann, M.D.,** received one of the first Distinguished Alumni Awards during the Alumni Weekend sponsored by the University of Tennessee College of Medicine Alumni Association in Memphis, October 28-29, 1982. The Award was created to recognize alumni of the University of Tennessee College of Medicine who have made extraordinary contributions to commercial, civic or health professional organizations.

Jeffery T. Nugent, M.D., orthopaedic surgeon, was nominated as President-Elect of the Medical Association of Atlanta for 1983. **Alvin H. Clair, M.D.,** was nominated as Southern District representative on the Board of Trustees.

The Georgia Obstetrical and Gynecological Society has named **Armand Hendee, M.D.,** as its new president. Dr. Hendee is a professor at Emory University School of Medicine.

Walter S. Brooks, Jr., M.D., of Atlanta, was elected a Fellow in the American College of Physicians. Dr. Brooks will be formally inducted at the College's Annual Session in San Francisco in April, 1983.

Kenneth N. Walton, M.D., of Atlanta, was recently chosen President-Elect of the Society of University Urologists at the Society's annual meeting in Chicago. In addition, Dr. Walton was honored by the American College of Surgeons with an appointment to their Urology Committee. He is a Louis McDonald Orr Professor of Surgery and Chairman of the Division of Urology at Emory University.

Sixth District

Milford B. Hatcher, M.D., of Macon, was cited recently in a local newspaper for more than 4 decades of

service to Macon and medicine. For 5½ years, Dr. Hatcher served in the U.S. Surgeon General's office in Washington, D.C. He teaches at Mercer University School of Medicine where he is Chairman of the Department of Surgery.

Seventh District

At its recent meeting, the Douglas County Medical Society elected the following officers for 1983: **Joseph G. Bussey, Jr., M.D.,** President and Delegate to MAG; **J. Gordon Barrow, M.D.,** Vice President and President-Elect; and **James D. Hull, III, M.D.,** Secretary-Treasurer and Alternate Delegate to MAG.

Ninth District

José E. Mendizabal, M.D., recently opened an office in Jonesboro to practice obstetrics and gynecology.

Tenth District

John M. Martin, M.D., of Augusta, was elected to the Board of Trustees of Mercer University in Macon. Dr. Martin also serves as a clinical professor at the Medical College of Georgia.

The Wills Memorial Hospital in Washington, GA, recently elected new officers for the Medical Staff. They are as follows: **Charles E. Wills, Jr., M.D.,** Chief of Staff; **John E. Pollock, M.D.,** Vice Chief of Staff; **Charles E. Pollock, M.D.,** Secretary.

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The MAG Advisory Committee to the Auxiliary

The Advisory Committee from the Medical Association of Georgia to the Auxiliary is a vital link between the two groups and is a valuable source of encouragement and inspiration to the planners of the many programs carried out by the spouses of Georgia physicians.

The 1982-1983 committee is made up of the following physicians: David C. Thibodeaux, of the Cobb County Medical Society, chairman; Brit B. Gay, Jr., Medical Association of Atlanta; Charles D. Hollis, Jr., Dougherty County Medical Society, and President of the MAG; Carl S. Pittman, Jr., Tift County Medical Society; Jack A. Raines, Muscogee County Medical Society, and Chairman of the Board of Directors of MAG; L. Newton Turk, III, Medical Association of Atlanta, and Past President of MAG; Perry M. White, Medical Association of Atlanta; and George R. Jones, DeKalb County Medical Society.



Dr. Raines



Dr. Thibodeaux, Chairman of the Advisory Committee from the MAG.



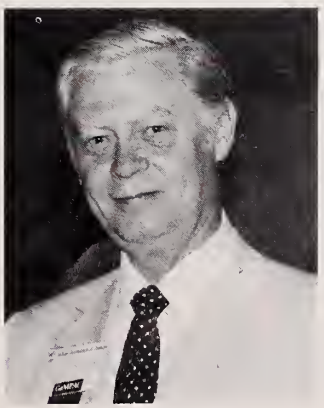
Dr. Jones



Mrs. Barbara Thibodeaux and two of the members of her Advisory Committee, Dr. Pittman (left) and Dr. Gay.



Dr. Turk



Dr. White



Dr. Hollis

VALLEY PSYCHIATRIC HOSPITAL

SOME THINGS WE'D LIKE YOU TO KNOW...

- VALLEY PSYCHIATRIC HOSPITAL IS A PRIVATE TREATMENT FACILITY DESIGNED TO TREAT PSYCHOLOGICAL/EMOTIONAL, ALCOHOL AND DRUG ABUSE PROBLEMS AND IS COMMITTED TO PROVIDE THE BEST CARE AND TREATMENT AT AN AFFORDABLE COST.
- VALLEY HOSPITAL HAS 100 LICENSED BEDS AND IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.
- THE HOSPITAL IS LOCATED AMIDST 80 ACRES OF BEAUTIFUL WOODLANDS, JUST TWENTY MINUTES FROM DOWNTOWN CHATTANOOGA.
- VALLEY HOSPITAL IS AN AFFILIATE OF HOSPITAL CORPORATION OF AMERICA, WHICH MAINTAINS A COOPERATIVE NETWORK AMONG THE 360 HCA AFFILIATED HOSPITALS.
- THE TREATMENT PROGRAMS AT VALLEY ARE DIVIDED INTO THREE MAJOR AREAS: **THE ADULT PROGRAM, THE ALCOHOL AND DRUG PROGRAM, AND THE ADOLESCENT PROGRAM.** THESE PROGRAMS ARE SERVED BY A COMPLETE RANGE OF TREATMENT THERAPIES AND ACTIVITIES PROVIDED BY A WELL TRAINED PROFESSIONAL STAFF.

FOR THOSE WHO COME TO VALLEY IN NEED OF HELP, WHETHER IT BE FOR THE DISEASE OF ALCOHOLISM, DRUG DEPENDENCY, EMOTIONAL PROBLEMS, THE TEENAGER UNABLE TO COPE WITH THE GROWING-UP PROCESS, OR ANY OF A BROAD RANGE OF PSYCHIATRIC DIFFICULTIES, WE SAY: "WELCOME, YOU HAVE JUST TAKEN THE FIRST STEP TO RECOVERY."

HOWEVER, VALLEY PSYCHIATRIC HOSPITAL IS MORE THAN JUST A MODERN, WELL-EQUIPPED FACILITY LOCATED ON A SCENIC SITE...

VALLEY IS PEOPLE:

THE PATIENTS:
WHO DESERVE OUR COMMITMENT TO QUALITY CARE, CONFIDENTIALITY, AND PROFESSIONALISM.

THEIR FAMILIES:
WHO SHARE OUR CONCERN FOR THE PATIENT'S WELL BEING AND HOPES FOR THE FUTURE.

THE STAFF:
WHO WORK WITHIN THE HOSPITAL TO PROVIDE THE BEST POSSIBLE TREATMENT AND ENVIRONMENT FOR EACH PATIENT.

OUR PRIORITY IS PEOPLE: THE PATIENT, THE FAMILY, AND THE STAFF

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"...particularly effective in soft tissue disorders including sports injuries,"[1] Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.

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See next page for brief summary of prescribing information.

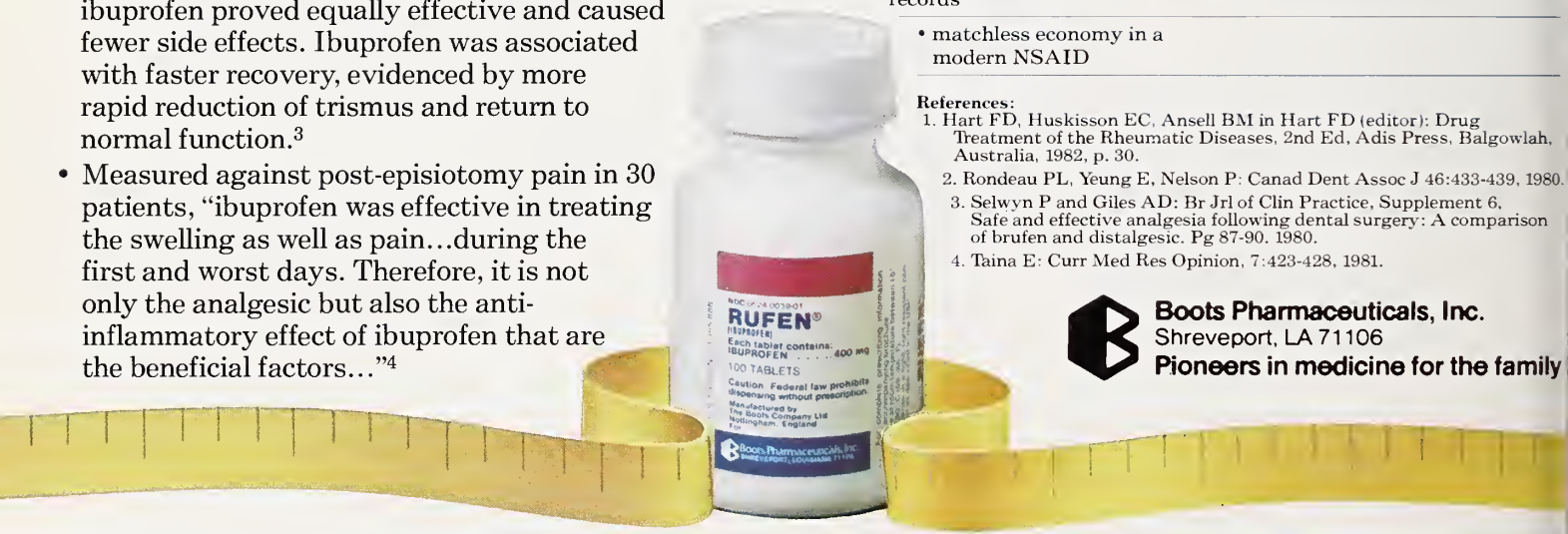
Measure RUFEN® (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."[2]
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.[3]
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."[4]

Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
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• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	



References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesic. Pg 87-90. 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.

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Shreveport, LA 71106
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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. *Special Senses:* hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photoallergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. *Do not exceed 2,400 mg per day.*

CAUTION: Federal law prohibits dispensing without prescription.

HOW THE MELTONS FOUND A CURE FOR MEDICAL SCHOOL COSTS.

Medical School Costs Are Going Up Each Year

While attending Tulane University, Ken and Gwenesta Melton decided to take advantage of the Health Profession Scholarship Program (HPSP) offered by the Army. They are now finishing their Graduate Medical Education in the Army.

Ken: I've recommended HPSP to my friends. They worry a little about the military side of it. In no way, I've told them, does the military aspect interfere with the educational process.

Gwenesta: Army medicine is very human. You don't have to fill out a million forms, or worry about seeing a certain number of patients for profit reasons.

Ken: After you've been in the HPSP a while, the Army offers you an option to spend your six weeks active duty at an Army Medical Center of your choice, anywhere in the country. You make three selections. I didn't get my first choice, but what I did get wasn't too bad. Tripler Medical Center in Hawaii.

The Army Medical Department offers an opportunity for financial support for individuals accepted to AMA or AOA accredited medical schools. Approximately 250 students starting their professional education in 1983 will be selected to participate in the Army's Health Professions Scholarship Program (HPSP). The HPSP pays for the participant's tuition, books, instruments (under $200/item) and, most academic fees required by the school while providing a monthly stipend of $556 for 10½ months plus active-duty pay for six weeks each year.

If you are a pre-med student and would like more information on the Health Professions Scholarship Program write or call collect:

AMEDD Personnel Counselor
HQ, US Army Forces Command
Building 128
Fort McPherson, GA 30330
(404) 752-3611

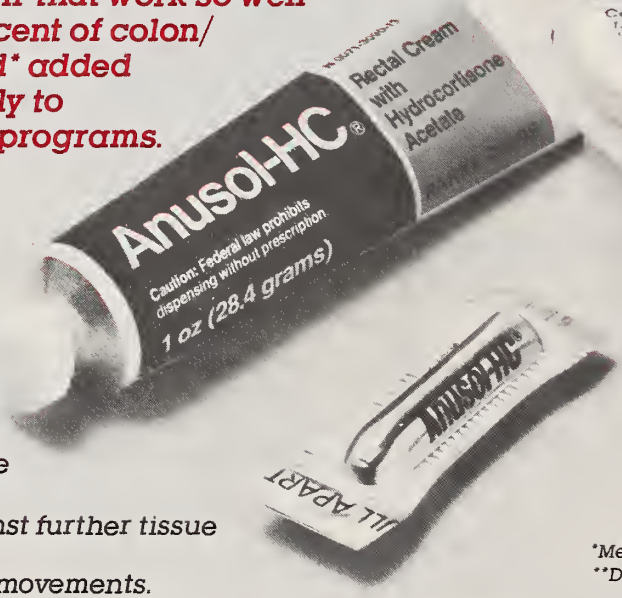
Famous Pairs.

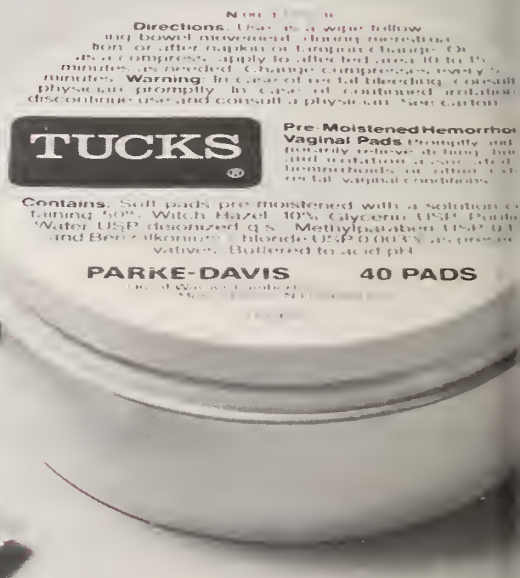


The Columbia space shuttle was a triumph of teamwork. And along with Young and Crippen went Anusol-HC Cream to treat prior anorectal conditions aggravated by "G-Force" stresses of exiting and reentering the earth's atmosphere.

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...another well-known pair that work so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs.





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Suppositories/Cream with Hydrocortisone Acetate

*The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders***

- ☐ *Antiinflammatory, to relieve itch, pain, and edema.*
- ☐ *Astringent, to protect against further tissue damage.*
- ☐ *Emollient, for easier bowel movements.*

Please see opposite page for brief summary of prescribing information.

**Meeting of Am Soc Colon/Rectal Surgeons, May 1980*
***Data on file, Marketing Research Dept, Parke-Davis*

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And, when pain is a special problem, Anusol® Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS® ***Pre-Moistened Hemorrhoidal/Vaginal Pads***

*The #1 hemorrhoidal** pad for added external relief and gentle cleansing.*

- ☐ *Soothes, cools, comforts, and cleanses irritated anorectal areas.*

Once pain and inflammation subside, for dual action recommend regular ANUSOL® and TUCKS.®

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Hemorrhoids and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0 mg; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS"

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, GA 30309-3990

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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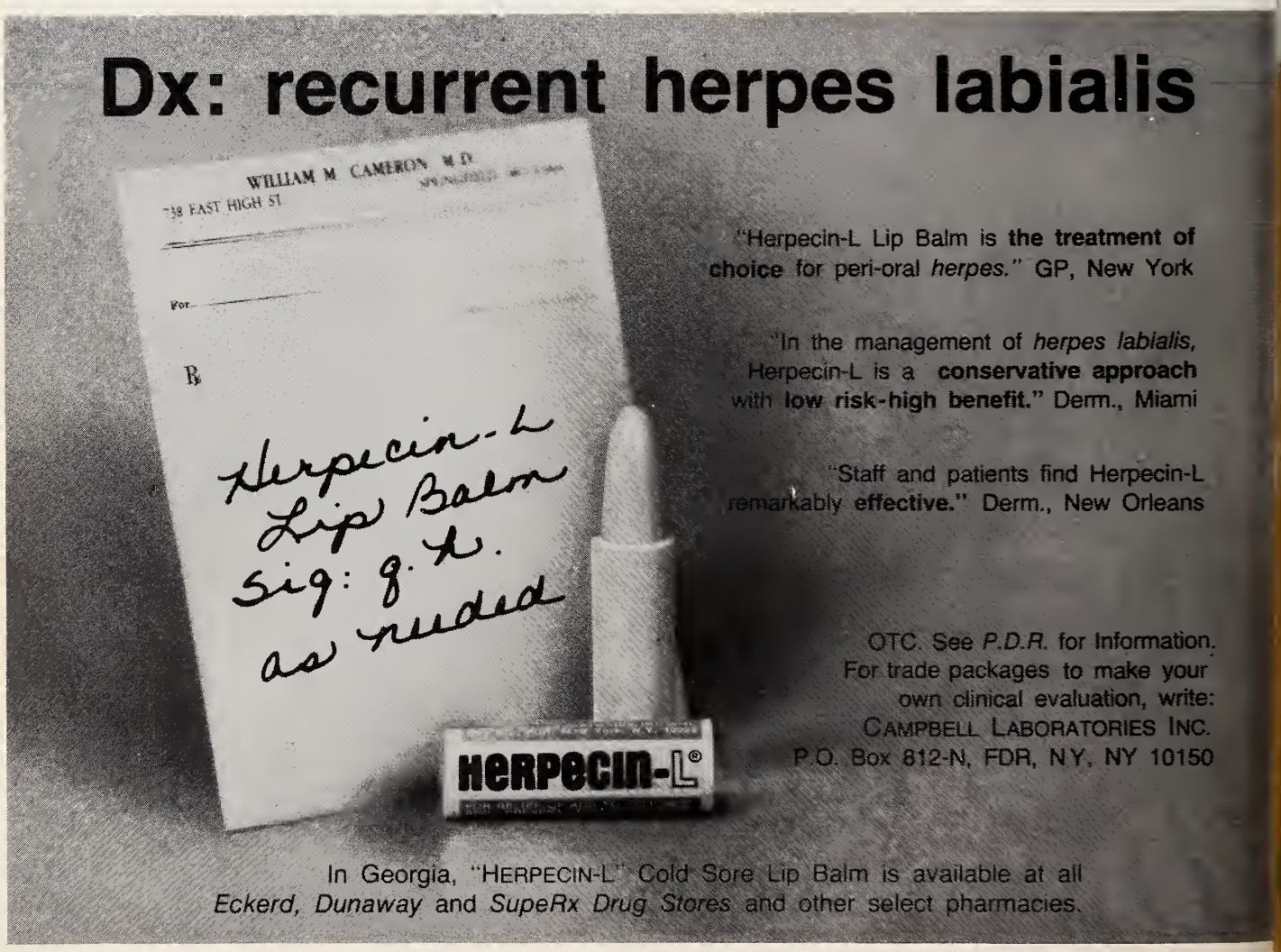
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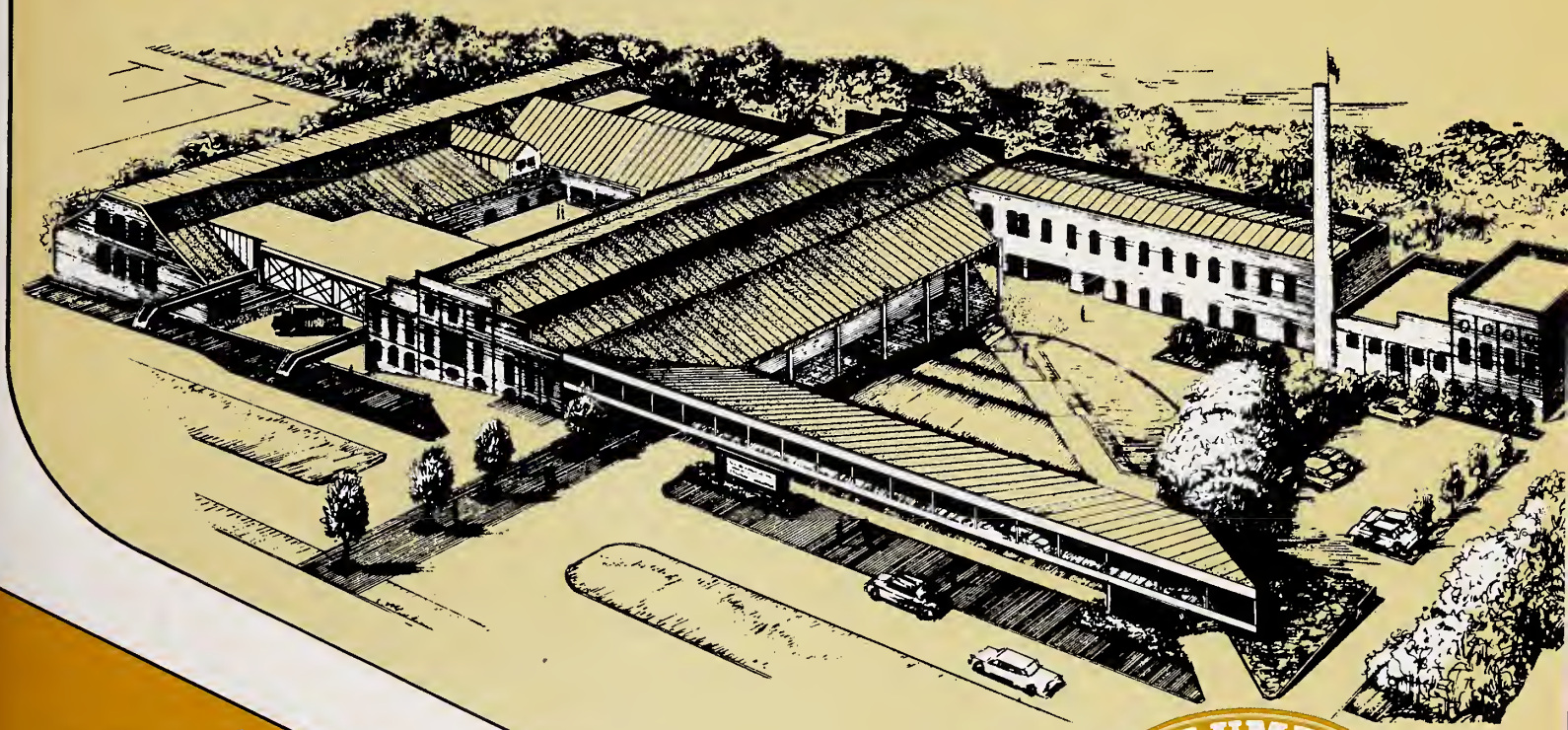
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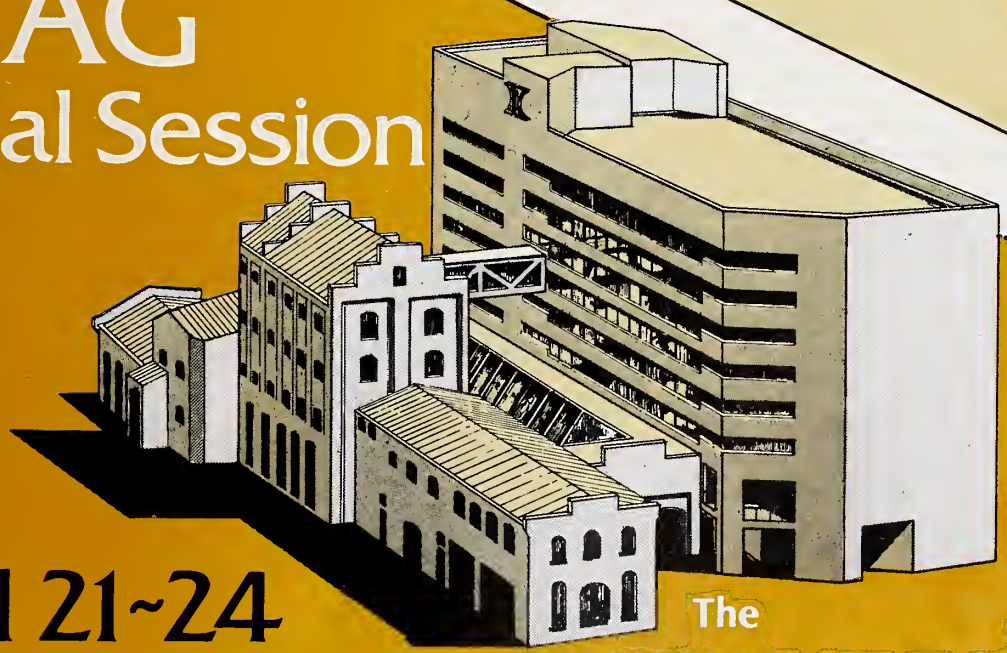


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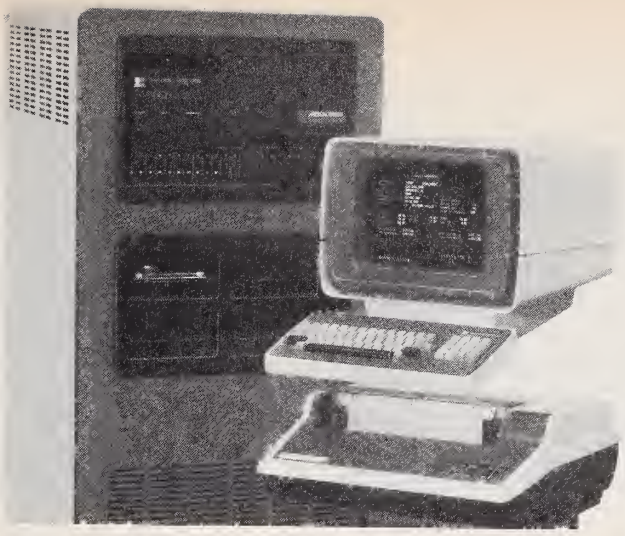
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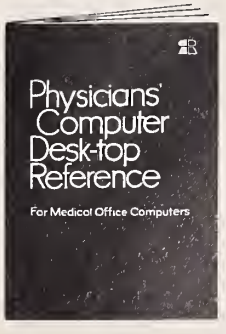
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Artwork by Richard Lyons, of Richard Heiman Advertising, Inc., Atlanta.

Letters to the Editor . . .

"My Billy Hates My Susan" — A Reader Responds

Dear Sir:

Dr. Sanford J. Matthews' article "My Billy Hates My Susan" in the December, 1982, *Journal of the Medical Association of Georgia* was interesting, and though Dr. Matthews waxed eloquent, correct conclusions cannot be derived from false premises. He stated it is his belief that "children are incapable of committing any of the seven capital sins" and considers lying and deceit as "habits of speech."

These beliefs are contrary to the teaching of the Bible which tells us that we are all sinners from birth. Acts of sin demonstrate to those around us the sin principle which already lies within each of us.

Thus, the "seven capital sins" or any other sin (sin is sin as far as God is concerned, and the Bible makes no such distinction) can be committed by children. I frequently see children sin. I have seen little ones lie, steal, kick, and bite one another and have terrible temper tantrums. I have seen two year olds who, after an examination and an injection of antibiotic, were so angry with me they would have killed me if they had a gun and the ability to use it.

The Bible not only teaches that children can and do sin, but it also gives us explicit instructions in how to deal with it. Proverbs 22:15 says "Foolishness is bound in the heart of a child; but the rod of correction shall drive it far from him"; Proverbs 13:24, "He that spareth his rod hateth his son: but he that loveth him chasteneth him betimes"; Proverbs 23:13, 14 "Withhold not correction from the child: For if thou beatest him with the rod, he shall not die. Thou shalt beat him with the rod, and shalt deliver his soul from hell."

In spite of the faulty premises, Dr. Matthews does recommend discipline with rules, punishments, and spankings and that is commendable. However, if we accept the premise that children are incapable of sin and we dismiss their lying and deceit as "habits of speech," we are less likely to realize the gravity of the situation when these things come forth from our children and less likely to deal with them in an effective, appropriate, time-tested biblical manner.

Thank you.

Sincerely,
W. Henry Gainey, M.D.
Emergency Medicine
Thomasville

Roentgen Cephalopelvimetry — One More Time

Dear Sir:

Your article and letter (re roentgen cephalopelvimetry in the July and October 1982 issues of the *Journal*, respectively) remind me of my OB/GYN professor who dismissed this topic by "I wear a size 7 hat — how big is my mouth?"

Yours truly,
Robert M. Webster, M.D.
Internal Medicine/Allergy
East Point

Ridgeview Institute

Ridgeview Institute is a private, nonprofit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

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The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

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Incidental Intelligence . . .

MAG Urges Caution on Foreign Medical Schools

At its meeting of January 8 the MAG Board of Directors received a report of the MAG Committee on Foreign Medical Graduates which outlined a number of deficiencies in the education provided at some foreign medical schools. As a result, the Board adopted this position:

"The Medical Association of Georgia urges all American citizens who may be considering the pursuit of medical education in foreign medical schools to review critically and conscientiously the curriculum, facilities, faculty and clinical training provided by the foreign medical school, insofar as graduation from that school may not lead to placement in a program of postgraduate medical education or to the license to practice medicine in the United States. The prospective student should, in fact, be aware that some foreign medical schools may offer expensive educational programs which are so deficient in quality as to allow their graduates virtually no prospects for the future practice of medicine in this State or in the United States."

Psychiatrists and the Law

In a carefully worded position paper on the insanity defense, the American Psychiatric Association (APA) has criticized a legal system that calls upon psychiatrists to testify beyond their medical expertise into matters of law and morality.

The statement, the first on the topic to be developed and adopted by the APA, is expected to spark heated debate among forensic psychiatrists, trial attorneys, and civil libertarians. Although the APA says in its foreword to the 23-page text that the statement "reflects the current thought and opinion of the vast majority of psychiatrists who are informed and concerned about the insanity defense issue," the report concludes recommendations that are likely to create controversy within the profession.

Certain to irk psychiatrists who frequently testify as expert witnesses are APA's guidelines on what Loren Roth, M.D., calls the "useful and scientifically valid role" for psychiatrists in the implementation of the insanity defense. Dr. Roth, Director of the law and psychiatry program at Western Psychiatric Institute in Pittsburgh and Chairman of the APA work group that wrote the statement, called this the most important recommendation in the new APA policy.

In a telephone interview with *American Medical News,* Dr. Roth said psychiatrists had been called upon to answer "ultimate issue" questions, such as whether a person is legally insane or had the capacity to appreciate the criminality of his conduct.

When such questions are posed, psychiatrists should decline to answer, he said, limiting their expert testimony to the "defendant's psychiatric diagnosis, mental state, and motivation at the time of the alleged act so as to permit the jury or judge to reach the ultimate conclusion about which they and only they are expert." When psychiatrists try to determine whether a defendant is legally insane, they are going "beyond their expertise, passing from the realm of psychiatry into the realm of morality and law," Dr. Roth said.

Although Dr. Roth said he would refuse to answer questions of legal insanity on the witness stand, such a response probably would cause him not to be called as an expert witness in most cases. The practice in most states, Dr. Roth said, is to ask psychiatrists such questions.

The statement's second most important recommendation, Dr. Roth said, suggests guidelines for legislation dealing with the disposition of violent people who are found not guilty by reason of insanity. According to the statement, this is the most significant area for reform in the current administration of the insanity defense.

Medical Costs and Care of the Elderly

The elderly benefit from home health care, but expanding such programs will not reduce overall health care costs, reports the General Accounting Office (GAO).

Home health care advocates have said that their programs can save money by taking some elderly patients out of hospitals and nursing homes and caring for them at home through frequent visits of health care professionals.

Despite frequently lower costs per patient, though, expanding home health services may increase the government's total health care cost because more people would be treated, the GAO found.

The report, which was based on a survey requested by Sen. Orrin Hatch (R-UT), did say that elderly people served by professional health and homemaker services live longer and are more satisfied than those without the services.

"This report says it may be cheaper to let things stay as they are because it doesn't cost anything to deny treatment to people," Hatch remarked. "I consider that dollar-wise, but people-foolish."

Hatch, Chairman of the Senate Labor and Human Resources Committee, is chief sponsor of a bill that would expand home health services to rural and inner-city areas where they are now unavailable. The bill has passed Hatch's own committee and is now in the Senate Finance Committee.

Abstracts from AHA, Ga. Affiliate, Scientific Sessions, October 1-3, 1982, Pine Mountain, Georgia

Involvement of Central Adrenergic and Cholinergic Neurones in the Hypertensive Response Associated with Morphine Withdrawal.

Jerry J. Buccafusco, Medical College of Georgia, Augusta.

In rats made physically dependent by a chronic, yoked infusion of morphine (35-100 mg/kg/day over 7 days), naloxone injection (5 mg/kg) elicited an immediate pressor response of 36 ± 2 mmHg lasting 30 min. This effect was central in origin since it was attenuated by prior ganglionic blockade with mecamylamine (30 mg/kg, iv). Both central adrenergic and cholinergic neurones have been implicated in mediating several behavioral signs of morphine withdrawal, with central adrenergic agonists (clonidine, C) and central cholinergic antagonists (hemicholinium-3, HC-3) producing inhibition of withdrawal signs. It was the purpose of this study to determine whether central adrenergic stimulation or central cholinergic inhibition also would inhibit the hypertensive response associated with morphine withdrawal. Arterial pressure was measured in freely moving rats through chronically implanted aortic catheters, and some animals were implanted stereotaxically with intracerebroventricular cannula guides to permit central infusionof HC-3 or intrajugular catheters to permit iv injection of C. Pretreatment with C (6-60 μg/kg) produced a dose-related inhibition up to 60% of the pressor response to naloxone in the dependent rat. Likewise, HC-3 (20 μg) reduced this response by 44%. These data suggest that intact central cholinergic neurones are required for the naloxone-induced hypertension and that central adrenergic receptors play an inhibitory role.

Alterations in Regional Myocardial Function After Heterogeneous Cardioplegia.

L. M. Dorsey, T. J. Colgan, J. I. Silverstein, C. R. Hatcher, Jr., R. A. Guyton, Carlyle Fraser Heart Center, Emory Univ. School of Medicine, Atlanta.

Coronary stenoses lead to heterogeneous delivery of cardioplegia during cardiac operations. This situation was simulated by occlusion of the circumflex artery during cardioplegic infusion in 40 canine right heart bypass preparations. Regional myocardial function (RMF, systolic shortening by sonomicrometer) was often diminished in spite of preservation of global function. The correlation between recovery of circumflex regional function and recovery of stroke work or dP/dt (at constant AoP, HR, and LAP) was poor ($r = .17$ and $.07$). Increases in afterload after arrest did not lead to further deterioration of damaged regions. Volume loading (CO 2 ˜ 5 L/min.) improved RMF even in severely damaged, bulging regions ($p < .05$). Regional distensibility (Δ length/ΔLAP) decreased by 41% ($P < .02$) in regions with poor protection and by 22% ($P < .01$) in regions with good cardioplegic protection. There was also an increase in resting length ($P < .001$) in both circumstances (5.2% and 3.7%). These changes in diastolic properties have not always been apparent in other experimental studies with less precise hemodynamic control. Heterogeneous cardioplegia causes heterogeneous changes in both diastolic distensibility and systolic function. These changes are poorly detected by examination of global ventricular function.

Results of Percutaneous Transluminal Coronary Angioplasty in Patients Who Have Had Previous Coronary Bypass Surgery.

John S. Douglas, Jr., Andreas R. Gruentzig, Spencer B. King, Jay Hollman, Emory University School of Medicine, Atlanta.

To avoid a second coronary bypass operation, percutaneous transluminal coronary angioplasty (PTCA) was performed in 70 patients in whom disabling angina pectoris developed due to vein graft stenosis or progression of atherosclerotic disease in the native coronary arteries 2 months to 10 years following coronary bypass surgery. Sixty-one patients (87%) had an initially successful angioplasty. Complications consisted of myocardial infarction in 3 patients. There were no deaths. Clinical success persisted in 51 patients (73%). Re-stenosis was common (50%) in the proximal or mid portion of the vein graft but infrequent (17%) at the coronary artery-vein graft junction and in this latter circumstance, repeat angioplasty is usually successful.

We believe that PTCA is a viable alternative to repeat operation in many patients who have recurrent angina pectoris following coronary bypass surgery. Early repeat angiography is indicated in these patients. PTCA is the treatment of choice in most patients with stenosis of the saphenous vein-coronary artery anastomosis.

Mega-Code Simulation in the Teaching of Advanced Cardiac Life Support for Infants and Children.

John E. Forestner, Sylvia Trower, Henrietta Egleston Hospital, Emory University School of Medicine, Atlanta.

The new advanced cardiac life support (ACLS) curriculum, introduced in the last year, utilizes a "mega-code" simulation as a format for teaching and testing of resuscitation skills. Commonly encountered adult clinical presentations with associated dysrhythmias are simulated, evaluated, and treated according to standard algorithms, which incorporate necessary elements of both basic and advanced cardiopulmonary resuscitation. Within the new ACLS curriculum, adaptation to specific needs of hospitals and emergency services is encouraged. In adapting the curriculum for use in a pediatric hospital, most adult algorithms were discarded, and new algorithms were developed for emergency simulations in infants and children. These included algorithms for asystole; asphyxiation due to foreign body, croup, or epiglottitis; paroxysmal atrial tachycardia; third degree atrioventricular block; and drug overdosage.

Effective use of these algorithms in formal ACLS courses, as well as in "code classes," has improved resuscitation skills among physicians and nursing personnel since their introduction. Algorithms for adult ACLS teaching are inappropriate for use in children. Effective systems for pediatric ACLS instruction can be developed, however, within the new curriculum format.

Enhanced Sensitivity of Coronary Artery to Nitroglycerin Under Hypoxic Conditions.
Ralph C. Kolbeck, Anjum S. Chaudhary, Allen J. Dennis, Department of Medicine, Medical College of Georgia, Augusta.

Nitroglycerin (NG) is frequently used in the clinical treatment of angina pectoris, although the basis of its therapeutic effect is controversial. It is well documented, however, that NG may play a role in the redistribution of flow to ischemic subendocardium. Whether this effect is the result of a direct coronary vasodilatation of oxygen deficient arteries or an indirect effect on ischemic myocardial metabolism is uncertain. In this study, incubated canine coronary arterial cylinders were used as a model to evaluate the influence of hypoxia on NG-induced arterial dilatation. Isometric force measurements were made using 4 mm cylinders of the left circumflex coronary artery. After 90 min of equilibration in a medium being gassed with 15% O_2 under 0.5 g tension, concentration-response curves to NG were determined. NG relaxed the cylinders, achieving 50% of maximal relaxation at a concentration of 3×10^{-6} M. The NG-induced relaxation was potentiated at lower oxygen tensions. Reduction of the oxygen level in the aeration gas to 5% resulted in a two-fold increase in the arterial response to 5×10^{-5} M NG at 25 min, and a four-fold increase at 35 min. The therapeutic effect of NG in clinical settings may thus be due to an enhanced sensitivity of hypoxic arteries to the drug, causing a regional increase in blood flow and a subsequent reversal of symptoms.

Functional Capacity After Percutaneous Transluminal Coronary Angioplasty and Bypass Surgery.
Bernhard Meier, Andreas R. Gruentzig, Maria Schlumpf, Emory University, Atlanta, and University of Zurich, Switzerland.

Multi-stage bicycle ergometry was done to assess changes in the functional capacity of patients undergoing percutaneous transluminal coronary angioplasty (PTCA) or, in case of failure, coronary artery bypass grafting (CABG). A total of 139 patients (pts) were divided into two groups, one with successful PTCA (111 pts) and one with failure of PTCA (28 pts). The pts with failure underwent CABG either as an emergency (10 pts) or an elective procedure (18 pts). All pts had exercise tests days before and 3 to 36 (mean 13) months after the procedure. Pts with successful PTCA were exercised additionally within two days after the intervention. The actual work capacity (aWC) was expressed in watts (W) according to the highest completed exercise stage. In the group with successful PTCA, the aWC increased from 76 ± 45 W (M ± SD) to 114 ± 43 W early after PTCA and 133 ± 38 W late after PTCA. The aWC's of pts with emergency and elective CABG were 72 ± 36 W and 81 ± 40 W before and 117 ± 37 W and 112 ± 37 W after surgery, respectively ($p < 0.01$ for all post-procedure values). Using the ratio of the aWC and the hypothetical work capacity, all three groups improved from a reduced level to a normal or near-normal level with a greater improvement after successful PTCA (from 49% to 88%) than after emergency CABG (from 50% to 83%) or after elective CABG (from 52% to 73%). Successful PTCA and to a lesser extent CABG improve the work capacity in a significant manner. A failing attempt of PTCA prior to CABG does not compromise the functional outcome of the operation regardless of whether it is done on an emergency or an elective basis.

Variability in Angiographic Assessments of Coronary Angioplasty.
Bernhard Meier, Andreas R. Gruentzig, Maria Schlumpf, Emory University, Atlanta, and University of Zurich, Switzerland.

The assessment of coronary angiograms is an important means to determine indication and success of percutaneous transluminal coronary angioplasty (PTCA). In order to investigate observer variability, the lesions of 10 patients (pts) were assessed twice by 3 observers in 3 oblique views using the films obtained before, immediately after, and 6 months after PTCA. The stenoses were traced from the cine projector and the diameters measured with a calibrated magnifying glass. A method using the mean result of 3 projections was designed in the hope of improving assessment reliability. Interobserver and intraobserver variabilities of this method and a method using only the result of the projection showing the most severe aspect of the stenosis were compared. The interobserver coefficient of variation (CV) was 6.4% using the mean of 3 projections and 7.0% using the projection only (NS). The intraobserver CV was significantly lower when the mean of 3 projections was used (10.5% vs. 16.0%, $p < 0.0001$). In conclusion, the assessment of 3 projections instead of one justifies the additional time required by significantly increasing angiographic assessment reliability which is of great importance in evaluating and comparing anatomical results of PTCA within and between centers.

Can Percutaneous Transluminal Coronary Angioplasty Be Performed in Patients with Total Coronary Occlusion?
Robert Savage, Jay Hollman, Andreas R. Gruentzig, Spencer King, III, John Douglas, Rose Tankersley, Emory University Hospital, Atlanta.

Of 1400 patients (pts) whose coronary arteriograms have been referred for evaluation, percutaneous transluminal coronary angioplasty (PTCA) has been performed on 850 pts with a primary success (PS) rate of 87% and a recurrence rate of 24%. To determine the efficiency of PTCA in pts with total occlusion, 39 pts (27 male, 12 female) had high grade coronary artery stenosis who progressed to total or functionally total occlusion during the interval between arteriogram and PTCA (73 ± 12 days, Mean ± SD). Stenosis progression during the interval was 10 ± 9%, with a range of 1 to 50%. Seven pts (18%) had arteriographic evidence of thrombus, and 3 pts had acute ischemia. PS was achieved in 26/39 (67%) pts, with a residual stenosis of 26 ± 6% which is a reduction of 74 ± 12%. There was no myocardial infarction, emergency coronary surgery (CS), or death. Three of the failures underwent elective CS; the remainder were managed medically. Follow up for the PS pts was 14 ± 11 mos., with exercise testing and arteriography at 6 month interval. Recurrent stenosis occurred in seven (27%) of PS pts.

In conclusion: 1) If the underlying anatomy is known and is of favorable morphology, PTCA can be performed with a high PS rate; 2) the long-term-patency of these pts is similar to others undergoing PTCA.

Arm Versus Leg Ergometry: New Data

A. L. Churchwell, K. A. Williams, J. Lutz, N. K. Wenger.
Emory University School of Medicine, Atlanta.

Arm exercise is reported to evoke a higher rate pressure product (RPP) [systolic blood pressure (BP) × heart rate (HR)] than leg exercise at any workload. This is based on BP measured by intraarterial catheter in nonexercising arm with other arm exercising, and/or with arms in different positions. To establish normal values for our laboratory, arm and leg ergometry were performed by 10 male medical trainees aged 24-29. Each normal subject exercised while sitting using standard bicycle and arm ergometry devices, with at least one hour of rest between tests; the order of the two tests was alternated. Each ergometer was rotated at 60 rpm, beginning at 0 workload, with work increments of 150 kpm/minute (min) every 3 min for 11 possible graded stages. A one min rest period was alloted after each stage. No subject reached the final stage of arm exercise, so comparison was for the first 10 stages. BP and HR were recorded immediately after each stage. In comparing each individual's arm and leg RPP, for 8 of 10 stages the arm and leg RPP did not differ (paired t test, $p > 0.05$). For both stages 4 and 5, arm RPP was > leg ($0.02 < p < 0.05$). Possible causes for this variation in arm vs leg RPP include differences in measurement techniques from prior studies and arm vasoconstrictive or blood flow changes related to arm position at exercise.

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MEDICAL MEETING CALENDAR

MARCH — 1983

24-25 — *Atlanta:* **Practical Use of Antibiotics: Update for the 1980s.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-27 — *Augusta:* **Spring Meeting, Georgia Chapter, American College of Surgeons.** Category 1 credit. Contact LaMar McGinnis, M.D., 365 Winn Way, Ste. 201, Decatur 30030. PH:404/292-2700.

27-29 — *Atlanta:* **MKSAP VI Part II — ACP.** Category 1 credit. Contact Dir., office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

28-29 — *Augusta:* **Genetics for the Practitioner.** Category 1 Credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

28-30 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

APRIL — 1983

6-8 — *Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

6-8 — *Atlanta:* **Perspectives in Parenteral/Enteral Nutrition.** Category 1 credit. Contact Lynn Smith, RN, Program Chairman, Metabolic Support Svc., Ga. Baptist Med. Ctr., 300 Blvd., NE, Atlanta 30312. PH:404/563-4496.

7-8 — *Atlanta:* **Otolaryngology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9 — *Lake Lanier Islands:* **Update of Hepatobiliary Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-9 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Dir., office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

8 — *Atlanta:* **Neurology.** Category 1 credit. Contact Dr., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-10 — *Atlanta:* **Hemodynamic Monitoring.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

10-14 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

11-13 — *Atlanta:* **Pediatric Neurology: Currents and Controversies.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

15-16 — *Atlanta:* **Atlanta Eye Congress.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

17-18 — *Atlanta:* **Internal Medicine.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24 — *Atlanta:* **Postgraduate Course — Pancreas, Liver, and Biliary Tract.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

25-27 — *Atlanta:* **Scientific Program of the Southeastern Surgical Congress.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

MAY — 1983

2-7 — *Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6-8 — *Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., Div. of Postgraduate Ed., 64 Inverness Dr. East, Englewood, CO 80112. PH:800/525-8651.

8-12 — *Atlanta:* **Cardiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

12-14 — *Atlanta:* **Pathology Update.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

18-22 — *Atlanta:* **Family Medicine Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-20 — *Columbus:* **Eleventh Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Ctr., P.O. Box 951, Columbus 31994. PH:404/324-4711.

27 — *Sea Island:* **Annual Meeting, Georgia Neurosurgical Society.** Contact Fremont P. Wirth, M.D., #4 Jackson Blvd., Savannah 31405. PH:912/355-1010.

JUNE — 1983

6-8 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, R.N., Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

9-12 — *Sea Island:* **Annual Meeting of the Georgia Society of Dermatologists.** Category 1 credit. Contact Robert M. Kelleher, M.D., 6500 Vernon Woods Dr., NE, Ste. D-8, Atlanta 30328. PH:404/256-9400.

13-17 — *Lake Arrowhead:* **Orthopaedics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-23 — *Atlanta:* **2nd International Symposium on Legionella.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Orlando, FL:* **Arthroscopy Need Not Be Frustrating (Operative Arthroscopy).** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-2967.

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Reference: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine,* unclassified document, ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980, pp 10-15

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WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
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Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
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The 129th Annual Session of the Medical Association of Georgia

On April 21, 1983, the Medical Association of Georgia's (MAG's) House of Delegates will convene at 8:00 p.m. in the Dining Gallery at the Iron Works in Columbus. The House of Delegates will be preceded by a General Session of MAG members at 7:00 p.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the scientific portion of the meeting was separated from the business portion and is held in November of each year.

Hotel Reservations

The Columbus Hilton is the headquarters for this meeting. All MAG delegates, alternate delegates, and officers will be receiving hotel reservation cards from MAG Headquarters. All others must make reservations directly with the hotel. The address is: Columbus Hilton, 800 Front Ave., Columbus, GA 31901. The Shannon will serve as the overflow hotel.

Registration

Registration facilities will be maintained in the Iron Works for delegates, alternate delegates, directors, and all members. Registration hours will be as follows:

Thursday, April 21 . . . 3:00 p.m.-7:00 p.m.
Friday, April 22 7:30 a.m.-12:00 noon
Saturday, April 23 8:30 a.m.-5:00 p.m.
Sunday, April 24 7:00 a.m.-12:00 noon

Message Center

The Auxiliary to the MAG will maintain a message desk in the Iron Works for the convenience of the membership. The messages will be posted on a bulletin board at the message desk.

Dr. Sammons to Address the House

James H. Sammons, M.D., Executive Vice President of the American Medical Association will address the MAG House of Delegates on Saturday morning, April 24. Dr. Sammons will speak on current issues facing us.

General Sessions

The opening General Session will be called to order by MAG's president, Charles D. Hollis, Jr., M.D., on Thursday, April 21, at 7:00 p.m. in the Dining Gallery. Featured at this opening ceremony will be the report of the President of the Auxiliary to MAG.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates. Newly elected officers will be installed during the Saturday House.

House of Delegates

The first session of the House of Delegates will convene on Thursday, April 21, at 8:00 p.m. in the Dining Gallery. Nominations for MAG officers will be made, and reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference Committees will be appointed, and all resolutions and reports will be referred by the Speaker to the appropriate Reference Committees.

The second session of the House of Delegates will convene at 9:00 a.m. on Saturday, April 23 in the Dining Gallery. Reference Committees will report to the House at this time.

Reference Committees

According to the Bylaws of the Association, all

resolutions and reports which contain recommendations must be referred to Reference Committees for open hearings. All members are invited and encouraged to appear before the Reference Committees to express their views. The Committees will open their hearings on Friday, April 22 at 9:00 a.m.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Thursday, April 21.

The election will take place during the House on Saturday morning April 23. The Tellers will pass out, collect and count the ballots and the results will be announced when the House reconvenes after the lunch break. All newly elected officers will be installed at that time.

President's Reception

The MAG will honor its president at a reception to be held at 7:00 p.m., Saturday, April 23. MAG President Dr. Charles Hollis, Jr., will present all of the awards at this time, and Dr. W. W. Moore, Jr., President-Elect, will address the group.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

GaMPAC Breakfast

GaMPAC will sponsor a breakfast on Friday morning, April 22 at 7:30 a.m. in the Ironworks.

Directors and Alternate Directors

District	Directors	Alternate Directors	Term Ending
1	Leon E. Curry, Metter	Douglas O. Cope, Statesboro	1985
2	Sammie Dixon, Tifton	Lannie Copeland, Moultrie,	1985
3	Virgle W. McEver, Jr., Warner Robins	Wentford A. Spears, Warner Robins	1985
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1983
7	Richard A. Griffin, Cartersville	Bannester L. Harbin, Jr., Rome	1983
8	Joe C. Stubbs, Valdosta	S. Wm. Clark, Jr., Waycross	1983
9	Rupert H. Bramblett, Cumming	Peter Lampros, Toccoa	1984
10	Wm. M. Headley, Miledgeville ('85)	Walter J. Revell, Jr., Louisville	1983
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Charles A. Lanford, Macon	1984
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Dan B. Stephens, Marietta	1984
Crawford W. Long Medical Society			
	William C. Holmes, Athens	E. Van Herrin, Athens	1985
DeKalb Medical Society			
	H. Duane Blair, Decatur	Charles McDowell, Decatur	1984
Dougherty County Medical Society			
	J. Dan Bateman, Albany	Frank F. Middleton, III, Albany	1983
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Robert A. Farrell, Rome	1984
Hall County Medical Society			
	John Reed, Gainesville	James H. Leigh, Jr., Gainesville	1983
Medical Association of Atlanta			
	William C. Collins, Atlanta	Bob G. Lanier, Atlanta	1983
	T. J. Anderson, Jr., Atlanta	W. Ben Spearman, Atlanta	1984
	J. Harold Harrison, Atlanta ('84)	William C. Waters, III, Atlanta	1985
Georgia Medical Society			
	Joe L. Nettles, Savannah	Clyde L. Olson, Savannah	1985
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1983
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Luther M. Thomas, Jr., Augusta	1984

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgement of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies, and all nominations must be accompanied by supporting biographic data and received at MAG Headquarters no later than March 1. If no nominations and supporting data are received, no award will be made. No nominations for this award will be accepted from the floor. If given, this award will be presented on Saturday, April 23. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at MAG Headquarters no later than March 1. They must be accompanied by biographic data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Saturday, April 23.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at MAG Headquarters no later than March 1. The recipient of this award will be selected by a three-man secret committee which will determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Saturday, April 23.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Presentation of the award is made at the Annual Session. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Saturday, April 23.

Officers of the Association 1982-1983

Board of Directors of the Medical Association of Georgia

Office Held		Term Ending
*PRESIDENT	Charles D. Hollis, Jr., Albany	1983
*PRESIDENT-ELECT	William W. Moore, Jr., Atlanta	1983
*IMMEDIATE PAST PRESIDENT	L. Newton Turk, III, Atlanta	1983
PAST PRESIDENT	H. Hilt Hammett, Jr., LaGrange	1983
PAST PRESIDENT	Earnest C. Atkins, Atlanta	1983
*FIRST VICE PRESIDENT	Virgle W. McEver, III, Warner Robins	1983
*SECOND VICE PRESIDENT	Eloise B. Sherman, Savannah	1983
*CHAIRMAN OF THE BOARD OF DIRECTORS	Jack A. Raines, Columbus	1983
*SECRETARY	William D. Logan, Jr., Atlanta	1984
*TREASURER	James H. Sullivan, Columbus	1984
*SPEAKER OF THE HOUSE	Jack F. Menendez, Macon	1983
*VICE SPEAKER OF THE HOUSE	James A. Kaufmann, Atlanta	1983
*VICE CHAIRMAN, BOARD OF DIRECTORS	Joe L. Nettles, Savannah	1983
EDITOR, *JMAG* (Ex-Officio member of Board)	Edgar Woody, Jr., Atlanta	1983

* (Denotes Executive Committee)

Component County Society Representation to the 1983 MAG House of Delegates

(1982 CMS Member Count for 1983 Delegates to Annual Session)

County Medical Society	Number of Delegates
Altamaha	1
Baldwin	2
Barrow	1
Bartow	1
Ben Hill-Irwin	1
Bibb	11
Blue Ridge	1
Burke	1
Camden-Charlton	1
Carroll-Haralson	2
Cherokee-Pickens	1
Clayton-Fayette	4
Cobb	12
Coffee	1
Colquitt	1
Coweta	1
Crawford W. Long	5
Decatur-Seminole	1
DeKalb	13
Dougherty	6
Douglas	1
Elbert	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin	1
Georgia Medical Society	11
Glynn	4
Gordon	1
Gwinnett-Forsyth	2
Habersham	1
Hall	5
Hart	1
Jackson-Banks	1
Laurens	2
Lumpkin	1
McDuffie	1
Medical Association of Atlanta	54
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	10
Newton-Rockdale	2
Oconee Valley	1
Ocmulgee	1
Ogeechee River	2
Peach Belt	3
Randolph-Stewart-Terrell	1
Richmond	17
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	2
Sumter	1
St. John's Parish	1
Thomas Area	3
Tift	2
Troup	3
Upson	2
Walker-Catoosa-Dade	2
Walton	1
Ware	3
Washington	1
Wayne	1
Whitefield-Murray	3
Wilkes	1
Worth	1

MAG Delegates to AMA

Delegates	Term Ending
J. Dan Bateman, Albany	12/31/84
C. Emory Bohler, Brooklet	12/31/83
F. William Dowda, Atlanta	12/31/83
Harrison L. Rogers, Jr., Atlanta	12/31/84
H. Hilt Hammett, LaGrange	12/31/83

Alternate Delegates	Term Ending
Carson B. Burgstiner, Savannah	12/31/83
Charles D. Hollis, Jr., Albany	12/31/83
Joe C. Stubbs, Valdosta	12/31/84
William W. Moore, Atlanta	12/31/84
S. William Clark, Waycross	12/31/83

Official Program

[All functions of the House of Delegates will be held in Columbus Convention and Trade Center (Iron Works)-Columbus]

Thursday, April 21

4:00 P.M. to 7:00 P.M. Registration of Delegates and Other Session Attendees
Location: 2nd floor Registration Booth

7:00 P.M. General Session
Location: Dining Gallery
Presiding: Charles D. Hollis, Jr., M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. David Thibodeaux of Marietta
Announcements
Recess

8:00 P.M. to 10:00 P.M. House of Delegates, First Session
Location: Dining Gallery
Presiding: Jack F. Menendez, M.D., Speaker, and
James A. Kaufmann, M.D., Vice Speaker
Presentation, Correction and Adoption of the Minutes of the 1982 House of Delegates
Appointment of Convention Committees
Nominations for Association Officers and AMA Delegates
Reports of Officers and Committees
Introduction of New Business
Announcements
Recess

Friday, April 22

7:30 A.M. Registration
Location: 2nd floor Registration Booth

9:00 A.M. Reference Committee Hearings

Saturday, April 23

8:00 A.M. Registration
Location: 2nd floor Registration Booth

9:00 A.M. House of Delegates, Second Session
Location: Dining Gallery

7:00 P.M. President's Reception
Presentation of Association Awards
Family Physician of the Year
Hardman Cup
Civic Endeavor Award
Distinguished Service Award

Brawner
Psychiatric Institute

ADULT TREATMENT SERVICE

ADOLESCENT THERAPY PROGRAM





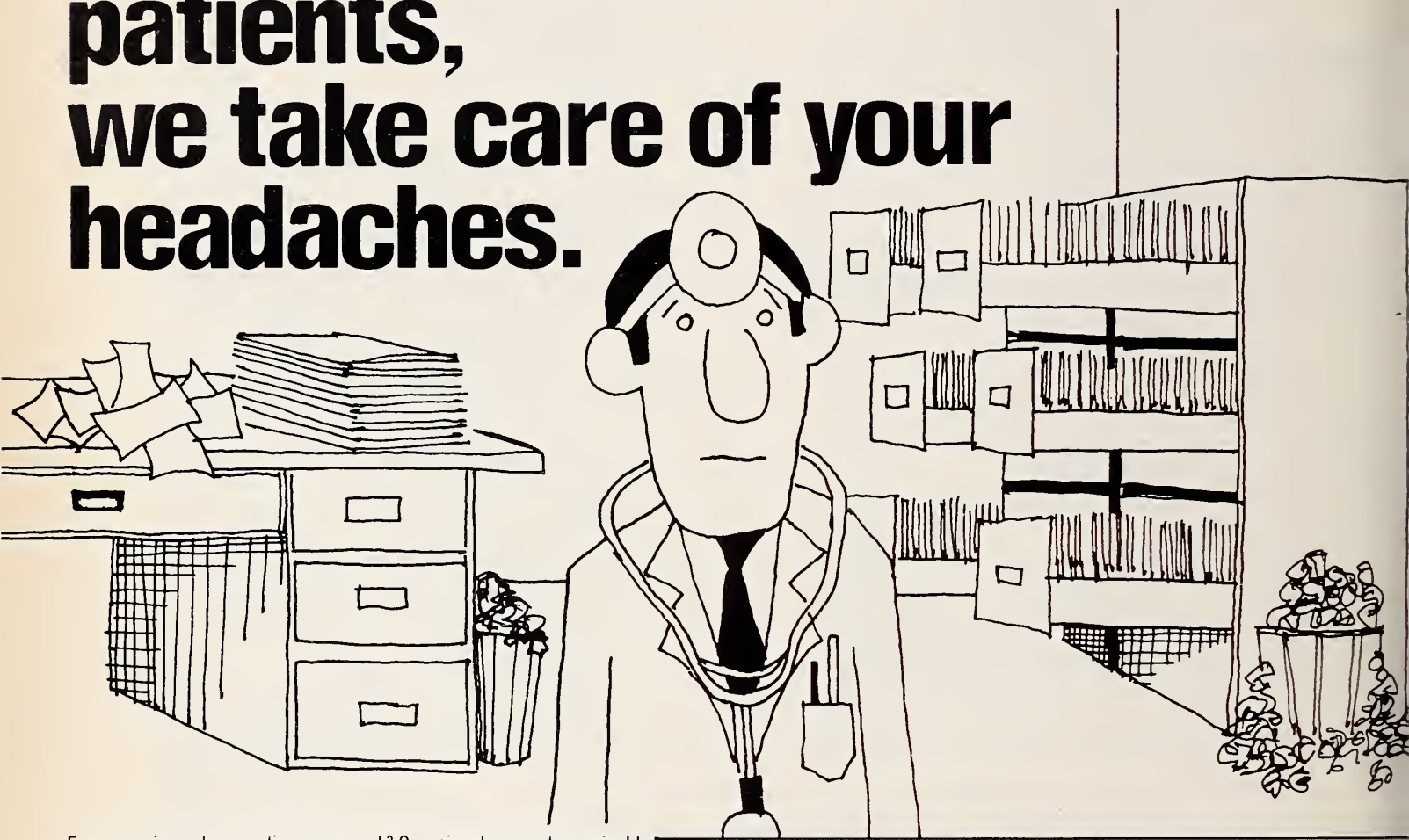
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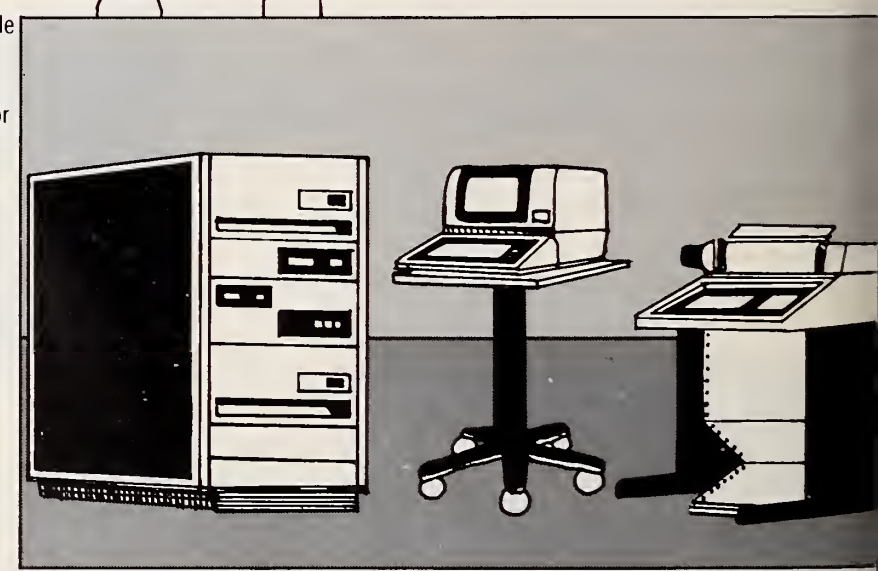
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J-9043-4 July 1981



The abused child will grow up someday. Maybe.

Each year, over one million American children suffer from child abuse. And over 2,000 children die from it.

But what about those who survive?

Statistics show that an abused childhood can affect a person's entire life.

Many teenage drug addicts and many teenage prostitutes report being abused children. So do juvenile delinquents and adult criminals.

Yet child abuse *can* be prevented.

The National Committee for Prevention of Child Abuse is a private, charitable organization that knows how to prevent child abuse.

But we need your help to do it.

We need your money. We need more volunteers.

Send us your check today, or write for our booklet.

Because if we don't all start somewhere, we won't get anywhere.

National Committee for Prevention of Child Abuse

Help us get to the heart of the problem.

Write: Prevent Child Abuse, Box 2866, Chicago, Illinois 60690

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Auxiliary to the Medical Association of Georgia

58th Annual Meeting

April 21-23, 1983
Columbus Hilton
Columbus, Georgia

1982-83 Theme: Pursue Today's Potential

President's Invitation

The Auxiliary to the Medical Association of Georgia is pleased to welcome you to the 1982-83 Convention in Columbus, Georgia. It will be a time when we can have fellowship and review our past year's accomplishments.

Business and social events have been planned. We hope this will be a most pleasurable occasion for all.

Mrs. David C. Thibodeaux
President
A-MAG

Welcome to Columbus

It is my pleasure to welcome you to the 58th Annual Convention of the Auxiliary to the Medical Association of Georgia.

The Auxiliary to the Muscogee County Medical Society is proud to host this convention at the Columbus Hilton — an 1841 flour mill turned into a luxury hotel. Activities are planned at the Columbus Ironworks Convention and Trade Center — once one of the largest producers of cast iron in the South; and at the Rankin House — an elegant 1850-1870 Victorian house museum. The Historic District, with its historic landmarks and restored ante-bellum mansions, is located nearby. So please join us for fun, fellowship, and Southern hospitality in this historic setting.

We hope that your visit with us will be pleasant; and if we can assist you in any way, please call on us.

Mrs. William R. McWhirter
Convention Chairman

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegates shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general meetings of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making the motion.
7. All persons appearing on the program must be seated near the platform when the meeting opens.

Program

THURSDAY, APRIL 21, 1983

3:00 to 5:00 **Registration and Information**

7:00 **MAG General Session — *Dining Gallery — Columbus Convention & Trade Center***
(All MAG and Auxiliary members and guests invited)
Presiding: CHARLES D. HOLLIS, JR., M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the Medical Association of Georgia — MRS. DAVID C. THIBODEAUX of Marietta
Greetings from Southern Medical Association Auxiliary — MRS. WILLIAM HUGHES, Montgomery, Alabama — President

FRIDAY, APRIL 22

8:00 to 5:00 **Registration and Information — *Fountain Room***
Hospitality and Exhibits — *Chattahooche Room*

10:00 **Pre-Convention Executive Board Meeting — *Empire Room***
Presiding: MRS. DAVID C. THIBODEAUX, Marietta, President, Auxiliary to MAG
Invocation
Business Meeting

12:00 **Auxiliary Luncheon & Fashion Show**
(All delegates, board members, Auxilians, and guests)
Presiding: MRS. DAVID C. THIBODEAUX, President, Auxiliary to MAG
Grace

2:00 **Auxiliary General Meeting — *Empire Mill Room***
Presiding: MRS. DAVID C. THIBODEAUX, President, Auxiliary to MAG
Call to Order
Spotlighting: County Presidents 1982-83
Invocation
Pledge of Allegiance and Collect
Solo
President's Greetings: MRS. DAVID C. THIBODEAUX
Welcome: MRS. WILLIAM R. MCWHIRTER, Convention Chairman
Response to Welcome
Introduction of Head Table: MRS. DAVID C. THIBODEAUX
Introduction of Past Presidents
Introduction of Special Guest
Greetings from the Medical Association of Georgia — CHARLES D. HOLLIS, JR., M.D., President
Address: MRS. TORRENCE P. B. PAYNE, New York, President, Auxiliary to the AMA
Introduced by MRS. MILTON B. SATCHER, Past President, A-AMA Membership Committee Member
Greetings from Auxiliary to Southern Medical Association — MRS. WILLIAM HUGHES, President, A-SMA
Introduced by: MRS. PERRY M. WHITE, Past President, Vice Councilor to Auxiliary to SMA
Business Meeting
Introduction of Pages
Credentials Report
Convention Standing Rules — MRS. JAMES H. MANNING, Parliamentarian, Auxiliary to MAG
Adoption of Program — MRS. ROBLEY D. SMITH, 2nd Vice President, Auxiliary to MAG
Roll Call — MRS. WILLIAM A. WOLFF, Recording Secretary, Auxiliary to MAG
Minutes — MRS. WILLIAM A. WOLFF, Recording Secretary, Auxiliary to MAG
Officers Reports
Committee Reports
Unfinished Business
New Business
Announcements

4:30 **Recess of Meeting**

7:00 to 9:00 **Auxiliary to MAG President's Entertainment — *Rankin House***
(Auxiliary Board members, MAG Committee on Auxiliary, Special Guest)

SATURDAY, APRIL 23, 1983

8:30 to 12:30 **Registration and Information — *Fountain Room***
Hospitality and Exhibits — *Chattahooche Room*

9:00 **Second Auxiliary General Meeting — *Empire Mill Room***
Presiding — MRS. DAVID C. THIBODEAUX, President, Auxiliary to MAG
Call to Order
Introduction of Guests
Introduction of Past Presidents
Memorial Service — MRS. JOHN WATSON, Memorial Chairman, Auxiliary to MAG
New Business Continued
A. Revised Report of Credentials Committee
B. Election of 1983-84 Nominating Committee
C. Report of Awards Committee
1. Achievement Award — MRS. JESSE D. HESTER, Chairman
2. James M. Brawner, M.D. Certificate of Excellence Award

— Mrs. Perry M. White, Chairman

3. **Safety** — Mrs. John H. Dorminy, III, Chairman
4. **Scrapbook** — Mrs. William A. Threlkeld, Chairman
5. **AMA ERF Award** — Mrs. George Galloway, Chairman
6. **Membership Award** — Mrs. Arlie Mansberger, Chairman
7. **Learning Center** — Mrs. Dent Purcell, Chairman
8. **Doctor's Day** — Mrs. Milton B. Satcher, Chairman

D. Report of the 1982-83 Nominating Committee— Mrs. Perry M. White, Chairman

E. Election of Officers

F. Installation of Officers — Mrs. John G. Bates, President Elect, A-AMA

G. Presentation of 1983-84 President's Pin and Gavel — Mrs. David C. Thibodeaux, Retiring President, Auxiliary to MAG

H. Inaugural Address and Announcements of 1983-84 Chairmanships — Mrs. George R. Jones, President, Auxiliary to MAG

I. Presentation of Past President's Pin — Mrs. Perry M. White, Past President

J. Announcements

12:00 Noon **Adjournment**

12:30 **Post Convention Board Meeting Luncheon**
Past President's Dessert at conclusion of Luncheon

A-MAG State Officers — 1982-83

President **Mrs. David Thibodeaux (Barbara)**
588 Heyward Circle, N.W., Marietta 30064
(Cobb) (404) 422-9233

President-Elect **Mrs. George R. Jones (Judy)**
1491 Council Bluff Drive, N.E., Atlanta 30345
(DeKalb) (404) 636-9565

First Vice-President **Mrs. Arlie R. Mangsberger, Jr. (Ellen)**
3128 Walton Way Ext., Augusta 30909
(Richmond) (404) 738-3471

Second Vice-President **Mrs. Robley D. Smith (Ann)**
814 W. 22nd Street, Tifton 31794
(Tift) (912) 382-2743

Third Vice-President **Mrs. William C. Tippins, Jr. (Barbara)**
1772 Tamworth Court, Dunwoody 30338
(DeKalb) (404) 394-2437

Area Vice Presidents

Northwest **Mrs. Jacob R. Harrison, Jr. (Nancy)**
504 Rainsong Road, Dalton 30720
(Whitefield-Murray) (404) 226-3719

Northeast **Mrs. Mark Brown (Julie)**
809 Windsor Court, Augusta 30909
(Richmond) (404) 736-0219

Southwest **Mrs. A. Frank Isele (Fay)**
2103 Chatham Drive, Albany 31707
(Dougherty) (912) 439-9073

Southeast **Mrs. W. Jack Smith (Eldred)**
725 Oglethorpe Avenue, St. Simons Island 31522
(Glynn) (912) 638-7819

Recording Secretary **Mrs. William A. Wolff (Nancy)**
1 Yosemite Court, Columbus 31907
(Muscogee) (404) 563-4042

Corresponding Secretary **Mrs. Brit B. Gay, Jr. (Evelyn)**
911 Vistavia Circle, Decatur 30033
(Medical Association of Atlanta) (404) 636-3976

Treasurer **Mrs. Maurice G. Patton (Louise)**
822 Windsor Court, Augusta 30909
(Richmond) (404) 738-2342

Historian **Mrs. Robert T. Anderson (Joan)**
No. 5 Etowah Terrace, Canton 30114
(Cherokee-Pickens) (404) 479-9025

Parliamentarian **Mrs. James H. Manning (Pellie)**
643 Kennesaw Avenue, N.W., Marietta 30060
(Cobb) (404) 428-1564

American Medical Association Auxiliary 1982-1983

President **Mrs. Torrence P. B. Payne (Betty)**
(home) 55 Grande Avenue, MD No. 16, Newburgh, New York 12550
(914) 561-5920

(AMAA office) 535 North Dearborn Street, Chicago, Illinois 60610
(312) 751-6166

President-Elect **Mrs. John G. Bates (Glenda)**
Box 329, Cotton Hill Road, Cutherbert 31740
(Randolph-Stewart-Terrell) (912) 732-3050 or
(912) 732-2154 office

Advisory Committee from the Medical Association of Georgia

Chairman — **David C. Thibodeaux, M.D.** 70 Tower Road, N.W.
Marietta 30062

Brit B. Gay, Jr., M.D. 1405 Clifton Road, N.E.
Atlanta 30322

Charles D. Hollis, Jr., M.D. 1610 North Valencia Drive
Albany 31707

George R. Jones, M.D. 1462 Montreal Road
Tucker 30084

Carl S. Pittman, Jr., M.D. 820 Tift Avenue
Tifton 31794

Jack A. Raines, M.D. 3228 Cody Road, Ste. 106
Columbus 31906

L. Newton Turk, III, M.D. 35 Collier Road, N.W.
Atlanta 30309

Perry M. White, M.D. 315 Boulevard, N.E., Ste. 312
Atlanta 30312

Auxiliary to Southern Medical Association

Councilor **Mrs. Milton B. Satcher**
1171 West Paces Ferry Road, N.W.
Atlanta 30327
Medical Association of Atlanta (404) 266-8361

Vice Councilor **Mrs. Perry White**
1547 Cave Road N.W.
Atlanta 30327
Medical Association of Atlanta (404) 233-2251

1982-1983 State Committees

Mrs. Olin S. Coffer Achievement Award **Mrs. Jesse D. Hester (Ruthie)**
2006 Hall Avenue, Tifton 31794
(Tift) (912) 386-2312

Allied Health Careers **Mrs. Louie H. Griffin, Jr. (Lou)**
3219 Ramsgate Road, Augusta 30909
(Richmond) (404) 736-7099

AMA-ERF (American Medical Association — Education and Research Foundation)
..... **Mrs. George W. Galloway, Jr. (Jean)**
140 River Court Parkway, N.W., Atlanta 30328
(Cobb) (404) 393-3226

Archives **Mrs. Roy W. Vandiver (Maureen)**
5656 Bahia Mar Circle, Stone Mountain 30087
(DeKalb) (404) 938-4551

James M. Brawner, Sr., M.D. Certificates of Excellence
..... **Mrs. Perry M. White (Katherine)**
1547 Cave Road, N.W., Atlanta 30327
(Medical Association of Atlanta) (404) 233-2251

Budget and Finance **Mrs. George I. Harrison (Linda)**
576 Pickett Road, S.W., Marietta 30064
(Cobb) (404) 422-2494

Mrs. Michel A. Glucksman (Irene)
1502 Wood Avenue, St. Simons Island 31522
(Glynn) (912) 638-9207

Convention (April 1983) **Mrs. William R. McWhirter (Ann)**
5030 Sears Court, Columbus 31907
(Muscogee) (404) 561-7596

Doctor's Day **Mrs. Milton B. Satcher (Ann)**
1171 West Paces Ferry Road, N.W., Atlanta 30327
(Medical Association of Atlanta) (404) 266-8361

Health Education (Learning Center) **Mrs. Dent W. Purcell (Ann)**
8314 Kent Drive, Mayfair, Savannah 31406
(Georgia Medical) (912) 355-6868

Impaired Physicians **Mrs. Jimmy R. Asbell (Alice)**
3093 Malvern Hill Drive, Macon 31204
(Bibb) (912) 742-6058

International Health **Mrs. Robert M. Packer, III (Susan)**
1602 Booth Street, Waycross 31501
(Ware) (912) 285-8077

Legislation **Mrs. William C. Tippins, Jr. (Barbara)**
1772 Tamworth Court, Dunwoody 30338
(DeKalb) (404) 394-2437

Long Range Planning **Mrs. Charles B. Thomas (Pearline)**
335 Westlake Drive, Athens 30606
(Crawford W. Long) (404) 549-5150
Mrs. Charles M. Ward (Mary)
200 Elladale Drive, S., Dawson 31742
(Randolph-Stewart-Terrell) (912) 995-2948
Mrs. Carlton B. Hudson (June)
15 Woodview Drive, Cartersville 30120
(Bartow) (404) 382-7664
Mrs. William C. Tippins, Jr. (Barbara)
1772 Tamworth Court, Dunwoody 30338
(DeKalb) (404) 394-2437

Membership **Mrs. Arlie R. Mansberger, Jr. (Ellen)**
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1926 — Albany — Mrs. William H. Myers, Savannah (Deceased)
1927 — Athens — Mrs. C. W. Roberts, Atlanta (Deceased)
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1931 — Macon — Mrs. Charles C. Harrold, Macon (Deceased)
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1935 — Atlanta — Mrs. J. E. Penland, Waycross
1936 — Savannah — Mrs. Ernest R. Harris, Winder (Deceased)
1937 — Macon — Mrs. William R. Dancy, Savannah (Deceased)
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1943 — Atlanta — Mrs. J. Lon King, Macon (Deceased)
1944 — Savannah — Mrs. Olin S. Cofer, Atlanta (Deceased)
1945 — No Convention
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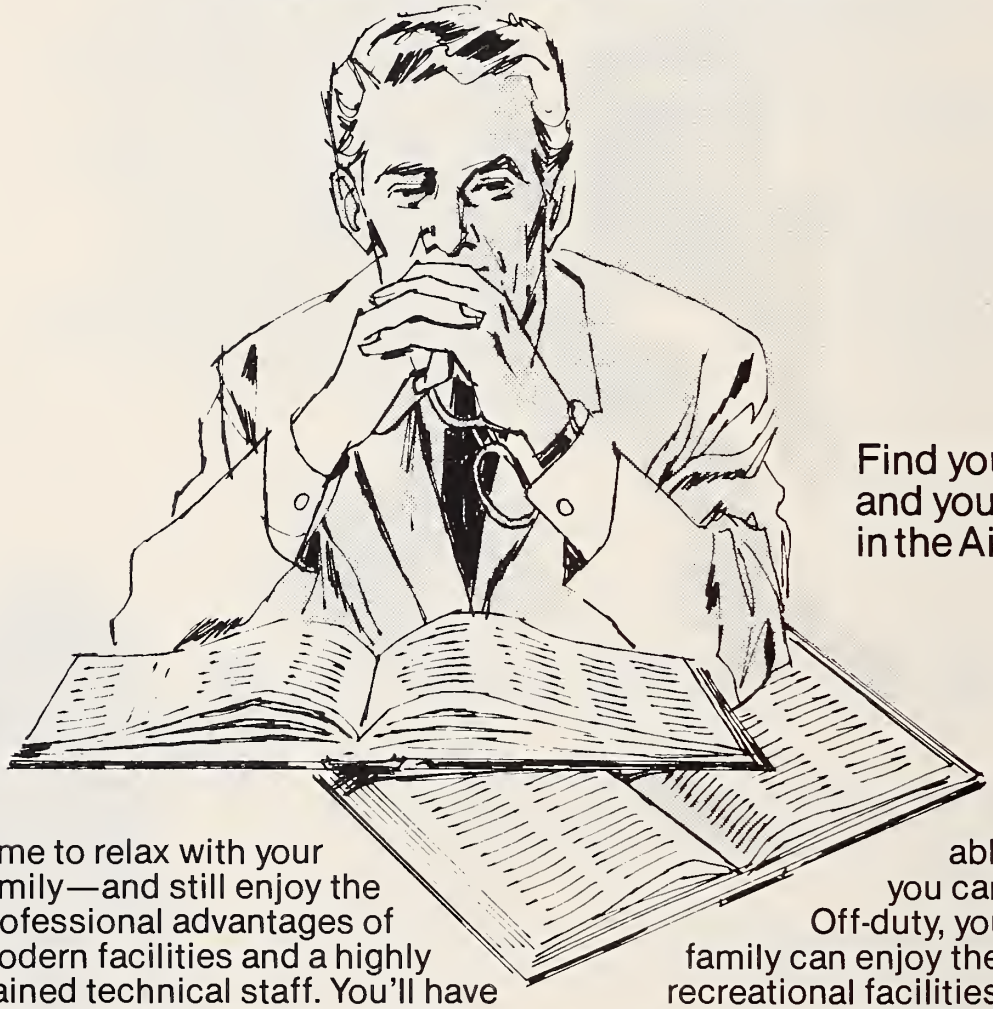
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Media exposure probably plays a more central role in shaping general public views than personal experience.

The Public Speaks — Part III

CHARLES W. McDOWELL, JR., M.D., *Decatur,* **and KEN WILLIAMS,** *Atlanta**

THIS IS THE THIRD in a series of articles on how the public views physicians. The Public Speaks — Part I and Part II appeared in the January and February issues of the *Journal*. The basis for this and the two previous articles was a public opinion survey conducted in August of last year. It was commissioned by the MAG Board of Directors at the request of the Public Relations Committee. To our knowledge, the survey is the largest ever conducted in Georgia on health care issues.

In this issue of the *Journal,* we shall focus on how the public views physicians, i.e., our fees, satisfaction with the latest visit to a physician's office, how we are selected, the decision on whether to retain our services, and "OUR IMAGE."

Is the Public Losing Faith?

Let us begin with the public image of physicians. Probably the most shocking finding is that 62% of those polled agree that "people are beginning to lose faith in doctors." In comparing Georgians' answers to the same question asked nationally, the percentages (62%) agreeing with the statement are identical.

Are Doctors' Fees Usually Reasonable?

Sixty percent of those Georgians asked said no. Nationally, the figure is 57%. Why does a higher percentage of our state's citizens believe doctors' fees are not reasonable? We should consider Georgia's per capita income. It is lower than the national average.

The percentage finishing high school or entering college is lower. We are less educated. And our non-white population is higher. Although one cannot "prove" that these are the reasons Georgians believe physicians' fees are not reasonable, these facts must be considered.

Time Spent With Patients — Enough?

When asked to agree or disagree with the statement, "most doctors spend enough time with their patients," 52% disagreed, 47% agreed.

Medical Needs of the Poor and Elderly

Are the poor and elderly able to get needed medical care? The majority in answering both questions say no. Fifty-seven percent say the poor are not able to get that care, and 51% say the elderly are in the same boat. Interestingly, in Georgia as in the general U.S., negative views toward care available to the poor and elderly are not shared widely by these groups themselves.

More than two-thirds of those interviewed said their personal relationships with the doctors staff is a very important influence in deciding to stay with a particular physician.

To summarize, if there is a public image problem for physicians, it involves three principal areas:

—fees and income
—the physician/patient interaction
—medical care provided to the poor and elderly

In nine other questions asked of Georgians concerning physicians' image, the results are mostly positive. The question was, "Please tell me if you agree or disagree with each of the following statements about doctors." You may also compare Georgians' answers with those of the U.S. as a whole.

* Dr. McDowell is Chairman of MAG's Public Relations Committee and practices ophthalmology; Mr. Williams is Director of Public and Professional Relations for the MAG. Send reprint requests to Mr. Williams at 938 Peachtree St., NE, Atlanta, GA 30309.

Do You Agree or Disagree with the Following Statements . . .

	Agree		Disagree	
	US	GA	US	GA
Your personal physician is accessible in an emergency	81	81	15	17
Doctors are too interested in making money	60	64	37	34
Doctors usually explain things well to their patients	55	53	44	47
Doctors act like they're better than other people	33	34	65	64
Most doctors take a genuine interest in their patients	68	68	30	31
Doctors are usually up to date on the latest advances in medicine	71	74	26	23
Most doctors are genuinely dedicated to helping people	80	77	20	23

Are Georgia's Patients Satisfied?

Since 1978, the American Medical Association has examined public satisfaction with various aspects of the latest physician visit. The question asked was, "Thinking about the last time you saw a medical doctor about yourself, would you say you were very satisfied, fairly, not too, or not at all satisfied with. . . ."

The length of waiting time before an appointment is very important to both identifying and keeping a personal physician.

Regarding Your Last Visit to Your Doctor, Were You Satisfied . . .

	% Satisfied			
			US	GA
	1978	1981	1982	1982
The way the doctor's staff treated you	92	92	93	92
The way the doctor explained things to you	85	87	90	90
The amount of time you had to wait in the office	74	73	82	82
The amount of time to get an appointment	81	86	89	88
The medical care you received	88	90	93	94
Overall satisfaction	87	90	94	94

Satisfaction with every aspect of the latest physician visit is increased over previous levels. This finding, in combination with deteriorating public views toward physicians in general, suggests that the "public image" of physicians is not based on personal experience. It is likely that media exposure plays a more central role in shaping general views while changes in physician practice are more closely tied to these satisfaction levels.

When we compare current patient satisfaction of Georgians with a national sampling in 1978, we find significant improvement in several areas. Eighty-two percent of Georgians surveyed were satisfied with the length of time they had to wait in the physician's office. Back in 1978, only 74% were satisfied at the national level. We believe part of the increased satisfaction is attributed to the higher ratio of physicians to population. Perhaps physicians have more time with each patient as, in almost every category, patient satisfaction has increased. The bottom line is 94% of Georgians polled indicate they are satisfied overall with their latest visit to a physician's office.

What can we learn from these data? Several interesting patterns emerge. The length of waiting time before an appointment is very important to both identifying and keeping a personal physician.

Advertising and fee levels are relatively unimportant to either decision. Almost one-third of patients go so far as to state that fees are *not* important influences on their decision to choose or retain their personal physician.

One very important influence in deciding to stay with a particular physician is how the doctor's staff treats the patient. Three-fourths say this treatment is a very important factor. More than two-thirds indicate that their personal relationship is a major influence.

A most important determinate of both decisions is the patient's perception of the physician's competence whether by credentials or experience. Clearly, almost all patients lack the expertise to make accurate judgments in this area, and research has indicated that most patients have little understanding of their physician's actual training or qualifications. Nevertheless, 97% of Georgians polled said my doctor's knowledge of medicine is *very important* in keeping a particular physician.

Choosing and Retaining a Personal Physician

As we examine why our patients select us as physicians, and why they choose to remain with us, let us examine two questions and the responding answers:

"Suppose you or a member of your family became sick and didn't have a regular doctor. If you were choosing a doctor, how important would . . . be — very important, fairly important, not very, or not at all important?"

	Very Important		*Fairly Important*		*Not Very Important*		*Not at All Important*	
	US	GA	US	GA	US	GA	US	GA
The recommendation of friends and relatives	63	70	26	21	5	4	6	5
The doctor's fees compared to other doctors in your area	38	48	28	25	20	16	12	11
The doctor's qualifications and training	89	93	8	6	2	1	1	0
Advertising that tells you about the doctor (for example, in the phone book or newspaper)	19	27	17	17	29	27	33	29
The length of time before the doctor can see you	74	77	19	16	4	4	2	1

"How important are each of the following reasons for keeping your personal physician — very important, fairly important, not very important, or not at all important?"

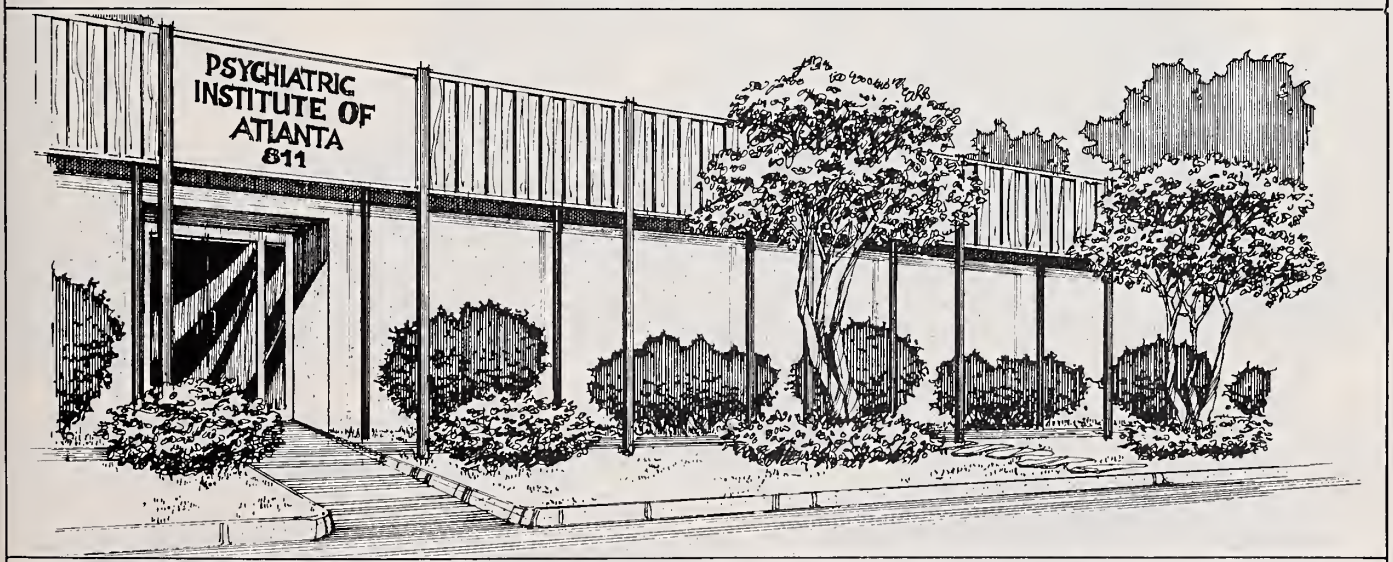
	Very Important		*Fairly Important*		*Not Very Important*		*Not at All Important*	
	US	GA	US	GA	US	GA	US	GA
Your personal relationship with the doctor	65	70	22	18	9	10	4	3
The doctor's fees compared to other doctors in your area	35	45	34	31	21	15	9	8
The way you are treated by the doctor's staff	75	79	20	17	3	4	1	1
The length of time before the doctor can see you	66	66	26	28	6	5	1	1
The length of time you wait in the doctor's office	51	54	32	31	14	12	3	3
Your doctor's knowledge of medicine	96	97	3	3	0	0	0	0

Looking Ahead

In the next issue of the *Journal,* we will examine competition in medicine — the public's view; acceptance and changes in how medical care is delivered; physician advertising; and the public's view of medical malpractice.

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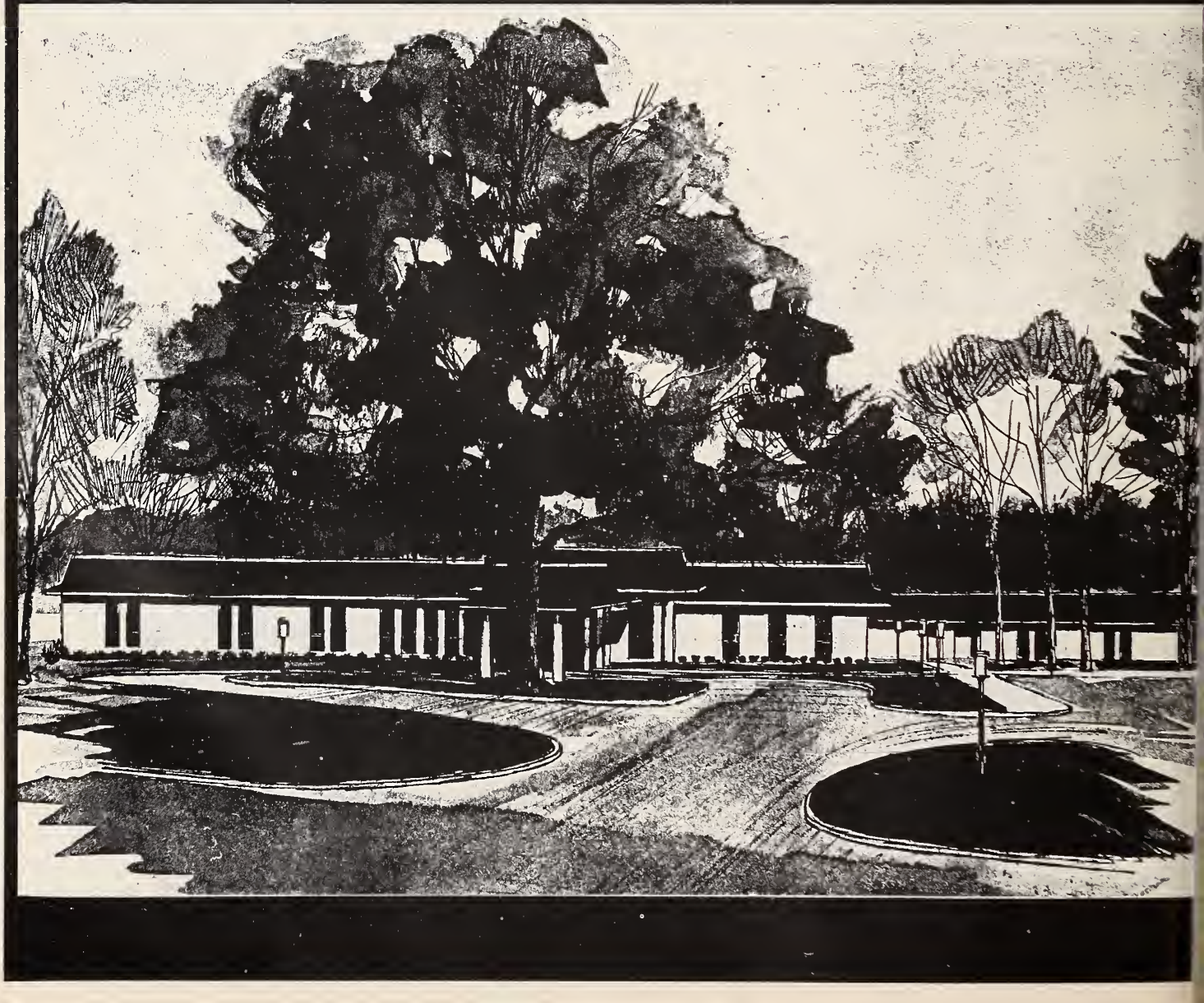
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This method has significant potential f eliminating or decreasing the incidenc adverse sequelae from conventional mechanical ventilators.

High Frequency Ventilation — An Overview

W. VICTOR TOMLINSON, M.D., and JOHN F. FISHER, M.D., *Augusta**

Abstract

High frequency ventilation is a novel technique of assisted ventilation employing low tidal volumes and high frequencies. This method has significant potential for eliminating or decreasing the incidence of adverse sequelae from conventional mechanical ventilators. Two types of high frequency ventilation are available; high frequency positive pressure ventilation (HFPPV) and high frequency oscillation (HFO). The major characteristics of HFPPV include a ventilatory frequency of approximately 3-5 times normal (that is, 60 to 100 cycles per second), tidal volumes equal to or less than anatomic dead space, and minimal chest wall movement. HFO employs ventilatory cycles ranging from 240 to 1800 cycles per minute, with tidal volumes as low as 20% of anatomic dead space. Although clinical experience with HFPPV is limited, wide clinical applications are feasible, particularly in the management of respiratory failure from a variety of causes.

PULMONARY BAROTRAUMA is a well recognized sequela of conventional mechanical ventilators. Recently, a technique using low tidal volumes and high frequencies was developed which avoids many of these adverse effects.[1-4] Presently, there are two types of high frequency ventilation: high frequency positive pressure ventilation (HFPPV)[14] and high frequency oscillation (HFO).[5-13] This paper reviews the theory and the experimental and clinical trials of HFPPV and HFO.

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Theory of HFPPV

HFPPV was developed in Sweden in 1967 to avoid the changes in cardiac output and venous return (or CVP) normally encountered in experimental animals on ventilators.[4] The major characteristics of HFPPV developed by Sjostrand and colleagues[4] include (a) a ventilatory frequency of approximately three times normal (i.e., 60-100 cycles per minute), (b) tidal volumes equal to or less than dead space, (c) minimal chest wall movement through maintenance of both positive intratracheal and negative intrapleural pressures throughout the respiratory cycle, and (d) probable reflex suppression of spontaneous breathing while achieving normal PaO_2 and $PaCO_2$. HFPPV achieves effective oxygenation and removal of CO_2 as a result of both bulk flow of air and augmented gas exchange.[5]

Experimental Trials: HFPPV

The initial experimental studies have been recently reviewed,[1, 14] and a detailed discussion will not be presented here. HFPPV was first used in dogs to achieve adequate ventilation with low mean and peak airway pressures.[15] It was further successfully employed during bronchoscopy in dogs. Through the use of HFPPV, the animals could be easily oxygenated during bronchoscopy with minimal chest wall movement.

Clinical Trials: HFPPV

Patients who require mechanical ventilation often attempt to breathe discordantly with the demand cycles of the ventilator. In a long-term study of two such individuals receiving HFPPV, both were calmed, and sedatives and/or respiratory depressants could be tapered or discontinued.[19] These patients

adapted more easily to HFPPV than to a conventional system. Borg et al.[2] developed a ventilator which delivered HFPPV (AGA Bronchovent) and demonstrated its utility in patients requiring bronchoscopy, laryngoscopy, and microlaryngeal surgery. HFPPV has been successfully used not only in adult patients undergoing routine laryngoscopy,[20] bronchoscopy,[17] and routine surgery,[27] but also in neonates and infants undergoing reconstructive surgery, or receiving post-operative support.[21] HFPPV was shown suitable for use in the high risk anesthesia patient and during bronchoscopic instrumentation into a diseased lung.[17, 20] Carlon,[24] using "high frequency jet ventilation," confirmed the efficacy of HFPPV in acute respiratory failure[22] and in patients with broncho-pleural fistulas.[23] The term "jet" was used because a higher working pressure was applied through an insufflation catheter of smaller diameter.[24] This was a minor modification of the basic circuit used by others.[4, 16, 20]

High Frequency Oscillatory Ventilation: Theory

Unlike HFPPV which employs frequencies of 60-100 Cpm, high frequency oscillatory ventilation (HFO) employs 240 to 1800 cpm.[5-14] At these high frequencies, effective alveolar ventilation and adequate oxygenation can be achieved using tidal volumes as low as 20% of anatomic dead space.[9]

The manner in which gas exchange is accomplished using HFPPV is not completely understood. However, Slutsky[9] determined that the combined effects of diffusion of oxygen and convection currents can account for the gas exchange at these frequencies. Fredberg[6] concluded that augmented diffusion in the central airways combined with molecular diffusion in the periphery accounts for most, if not all, of the gas exchange. His calculations were based on a study[8] which was deliberately designed to eliminate bulk flow as a method of gas exchange. The apparent paradox of ventilating the peripheral airways with tidal volumes much lower than dead space is a result of the combined effects of augmented diffusion of gases and convection currents which provide the mass transport necessary for adequate gas exchange.[6, 9]

Experimental Trials: HFO

Studies employing HFO were initially carried out in dogs and rabbits at frequencies of 150-600 cycles per min.[11] Adequate alveolar ventilation was maintained at low peak airway pressures and tidal volumes lower than or equal to dead space. A later study[8] confirmed these findings and documented that cardiac output was not affected by HFO as compared to conventional ventilators.

Clinical Trials: HFO

The earliest clinical trial of HFO employed a piston pump operating at 900 cycles per min.[5] Compared with conventional mechanical ventilation, a significant reduction in calculated shunt fraction (Qs/Qt) was noted in patients receiving HFO without change in PCO_2 or cardiac output. The authors concluded that 48-77% shunt reduction could be achieved in patients with chronic obstructive pulmonary disease (COPD). These and other data suggested that augmented gas diffusion occurs in HFO thereby improving $\dot{V}/Q$ mismatch.[13] Similar improvement in oxgenation has been noted in neonates with respiratory distress syndrome (RDS) using frequencies of 480 to 1200 cycles per minute.[10] The average FIO_2 required to maintain adequate oxygenation in each of these infants was strikingly reduced from a mean of 66% to 41%. In contrast to earlier animal studies,[11] the neonates required higher mean airway pressures using HFO as compared to conventional mechanical ventilation.[10] This discrepancy can be attributed to the extensive collateral ventilation in dogs which is absent in human infants and to the fact that the dogs were anesthetized and paralyzed and the infants were not. The highest frequency of HFO applied in clinical trials has been 1800 cycles per minute in premature infants with RDS.[12] Maximum oxygenation and CO_2 elimination occurred in these infants at a frequency of 900-1200 cycles per minute and tracheal airway pressure was less than 50% of oscillator output airway pressure. HFO at 1800 cpm has been used in an uncontrolled study[26] of infants with respiratory failure secondary to hyaline membrane disease. An encouraging 92% survival was reported. Thus, improved survival appears to be possible in infants with RDS using HFO. More experience is obviously needed with this technique.

Conclusions

On the basis of successful clinical trials, HFPPV is used daily in Sweden.[1, 2, 14] Clinical experience with HFO is presently limited.[5, 6, 8, 9, 13] Each method has been employed principally in patients with restrictive pulmonary disease. However, therapeutic application of HFO to patients with COPD is feasible. First, in patients with COPD, functional alveoli are often overinflated using conventional mechanical ventilators, owing largely to regional differences in lung compliance. HFO could theoretically minimize such barotrauma.[25] Second, substantial reduction in the need for sedatives and neuromuscular blocking agents is possible with HFPPV, since patients apparently have little difficulty adapting to the respirator. Third, reduction of ventilation-perfusion mismatch would be an important contribution to patients with COPD or with respiratory failure from a variety of causes. Fourth, HFPPV appears to enhance the clearing of pulmonary secre-

tions by a mechanism not presently understood.[19] This effect could be used to advantage intermittently in patients who have bronchopulmonary infections with inspissated secretions or poor cough reflex.

Other possible applications of HFV include the ventilatory support of neonates with meconium aspiration (Karlson, unpublished observations), patients with congestive heart failure, or patients with thoracic trauma and flail chest injuries where chest wall motion must be minimal. Long-term effects on mucociliary function, surfactant production, and other metabolic parameters have yet to be studied. Clearly, controlled clinical trials are required to determine the full merits of these new techniques.

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1. National Interagency Council on Smoking and Health. *The Smoking Diges* Progress Report on a Nation Kicking the Habit. 1977.

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Before prescribing, please consult full product information, a brief summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: Hypersensitivity; use with other xanthines.

Warnings: Status asthmaticus is a medical emergency. Excessive doses may be expected to be toxic.

Usage in Pregnancy: Safe use in pregnancy has not been established; do not use in pregnant women unless the potential benefits outweigh the possible hazards.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, acute myocardial injury, congestive heart failure, or peptic ulcer. Chronic high dosage is usually associated with gastrointestinal irritation.

Adverse Reactions:

Gastrointestinal—irritation, nausea, vomiting, epigastric pain, headache, hematemesis, diarrhea.

Central Nervous System—stimulation, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.

Cardiovascular—palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.

Respiratory—tachypnea, respiratory arrest.

Renal—albuminuria, increased excretion of renal tubule and red blood cells.

Others—fever, dehydration.

Overdosage:

Symptoms—In infants and small children: agitation, headache, hyperreflexia, fasciculations, and clonic and tonic convulsions. In adults: nervousness, nausea, vomiting, tachycardia, and extrasystoles.

Therapy—No specific treatment. Discontinue drug immediately. Provide supportive treatment as indicated. Ipecac syrup for oral ingestion. Avoid sympathomimetics. Sedatives such as short-acting barbiturates help control CNS stimulation. Restore the acid-base balance with lactate or bicarbonate.

Drug Interactions: Toxic synergism with sympathomimetic bronchodilators may occur.

Dosage and Administration:

Usual Adult Dosage—15 mg/kg every 6 hours, up to four times a day. Titrate the dosage individually.

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BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCAROIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCAROIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCAROIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCAROIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCAROIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCAROIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCAROIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCAROIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCAROIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCAROIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCAROIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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"I shop, cook and can plant flowers again."

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PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



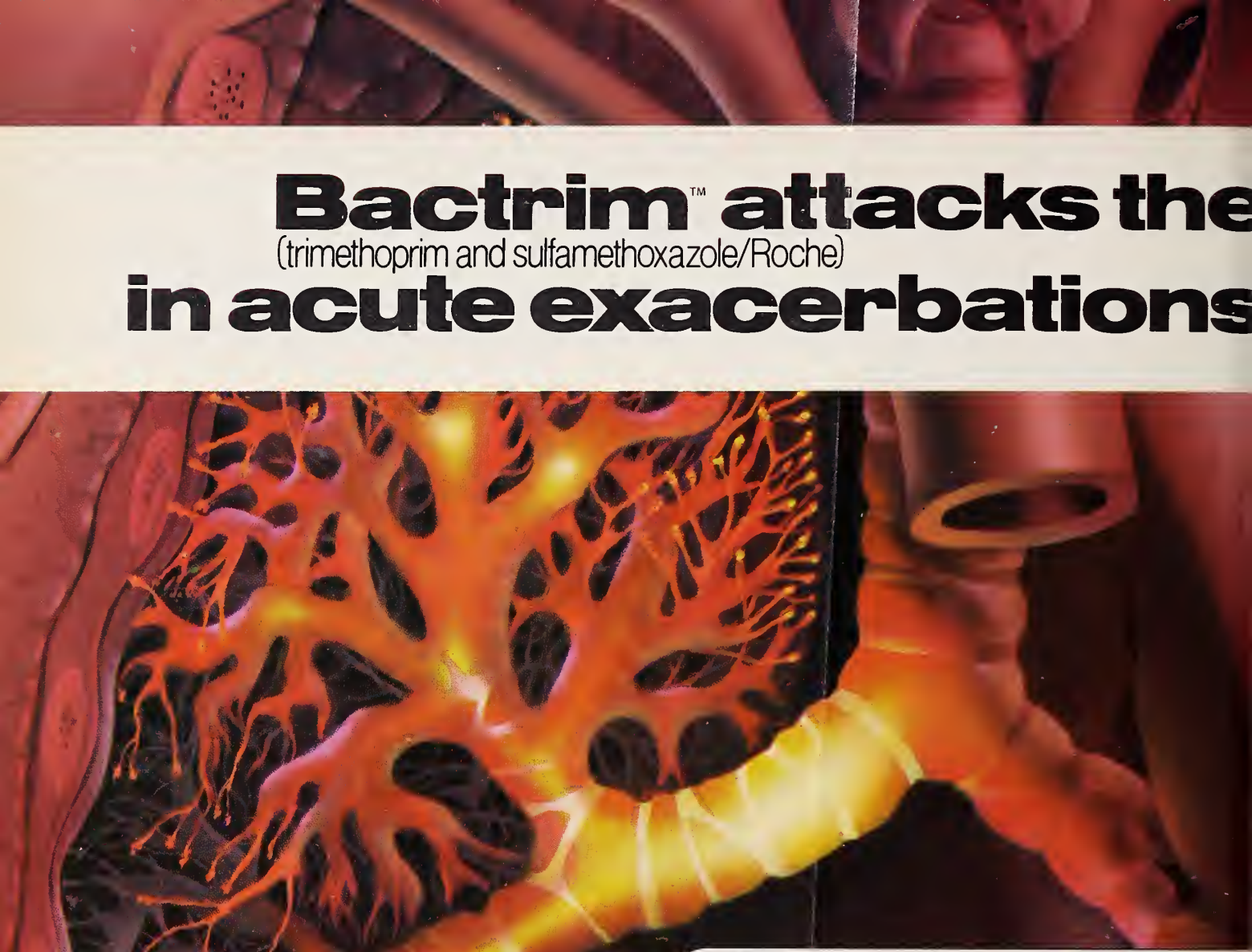
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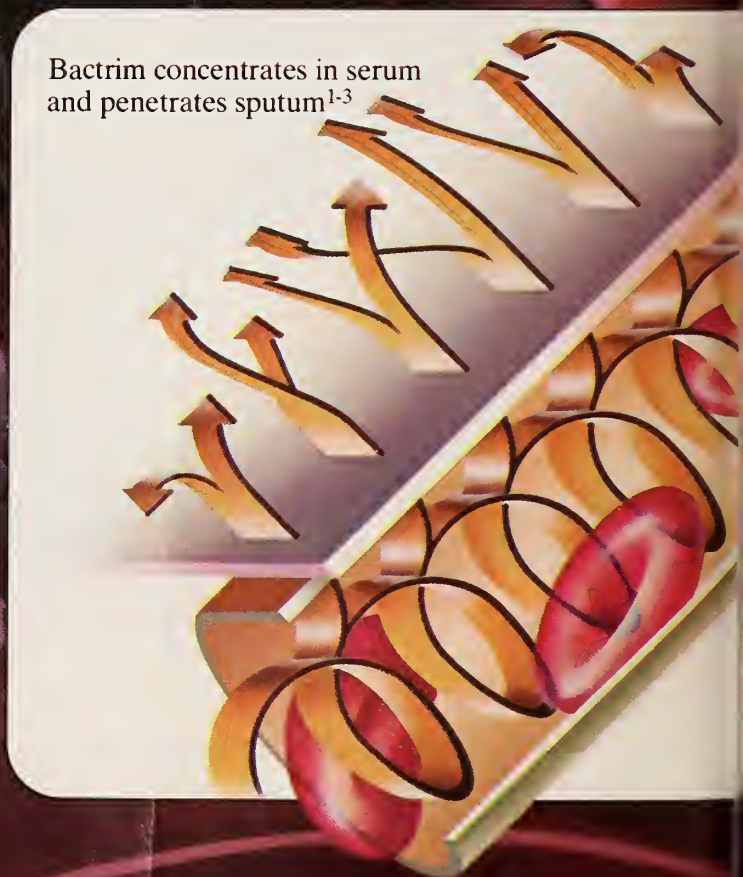
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*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Bactrim™ attacks the
(trimethoprim and sulfamethoxazole/Roche)
in acute exacerbations





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ROCHE

major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

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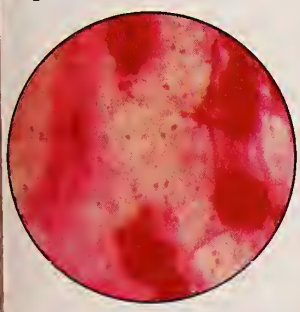
Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection 6*(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

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For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
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This account of Dr. Hallum's experience working with the Navajo Indians in Arizona makes interesting reading

An Interview With Dr. Alton V. Hallum, Jr.

EVELYN WARD GAY, ***Decatur****

DR. ALTON V. HALLUM, JR. had a dream: to live and practice his profession among the Indians of the Southwest. Recently, the Atlanta obstetrician and his wife, Elaine, realized his dream when they spent 3 weeks on a Navajo reservation in Arizona. This was his first real-life experience in sharing the deprivations of a different tribe of people, and he was much impressed with what he found.

"They care about their people and the land," he said. "They are striving to reclaim their customs and to stay on the reservations. They prefer it that way. Their philosophy is simple — to live in harmony with their environment."

Dr. Hallum began his quest for a spot in the Indian Health Service program about 2 years ago when the American College of Obstetrics sent out a call for volunteers to relieve the regular physicians at certain hospitals. The hospital where he eventually was placed was at Ft. Defiance, Arizona, 7 miles from Window Rock, the capital of the Navajo Nation. Window Rock, he explained, is about 30 miles from Gallup, New Mexico, and about 250 miles from Albuquerque.

"The hospital there has a good O. B. unit and is small," he said, "so that you can get to know the people."

After flying to Albuquerque, Dr. and Mrs. Hallum rented a car and drove to the Ft. Defiance Indian Hospital. When they arrived, they were assigned a mobile trailer which was located within 100 yards of the hospital. It was furnished with only the barest necessities, but it did have a telephone.



Dr. Alton V. Hallum, Jr., foreground, shows off some of the magnificent scenery surrounding the hospital where he worked on the Navajo Indian Reservation.

One of his most pleasant surprises came the first night he was on duty.

"There I was, 2000 miles from home and not expecting to see anyone I knew," he related. "Then I met one of the regular physicians, a pediatrician who had been stationed there in military service and had chosen to stay on with the Public Health Department. During our conversation, I learned that he had a sister in Atlanta, and it turned out that she is a patient of mine."

The hospital where he worked has places for 4 obstetricians, he said, but only two of those places are filled. When one of the doctors is on vacation and only one volunteer is available, that still means they are two short. There are not always enough volunteers to go around, but at least one can go on vacation when a substitute is available.

* Mrs. Gay is a member of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.



On the Navajo Indian reservation the women do most of the work growing crops. Here a woman shucks corn.

Dr. Hallum explained that the medical system used on the reservation is interesting. Each morning and night, clinics are held, and these clinics refer patients to the hospitals. There is a problem, however, since there is only one OR team. When that team is off duty, sometimes patients must be transferred 60 or 70 miles by ambulance to another hospital. But the Indian women work hard and usually are healthy, he said. They will walk a long way and then catch the bus to get to the clinics. These are the younger ones who are more "tuned in," he said. The older, more traditional families do not accept the white man, but they do have respect for his medicines.

The Indians also have different ways of their own for diagnosing and treating the sick. Their medical men are trained for years under the older men. Some of them are called "bone rattlers." The practitioner of this art rattles bones, spreads them on the floor of the patient's hogan, and reads them to make his diagnosis. He often uses herbal medicines to treat their ailments. Pictographs also are employed in diagnosing and treating patients. The medical man draws pictures on the floor in the dirt, depicting the family members, and then talks and sings out the family's problems. Then there are the "chanters." When traditional women are delivered of their babies, all women in the family attend the birth. Sometimes there are 5 to 10 of them lining the walls, chanting and moaning. Dr. Hallum says that these people can be distracting at times, but they are never in the way.

While he was on the reservation, 60 Indian babies were born. Dr. Hallum delivered the babies of 20 high-risk mothers. The remaining 40 normal births were taken care of by nurses, some of them Indians and some contract nurses. There were 4 nurse-midwives.

The Navajo Indian Nation, with some 300,000 members, is the largest in the area and covers a land



An expert photographer, Dr. Hallum spent much time photographing the Indians and their art work. As much as 500 hours of work often go into the weaving of valuable Navajo rugs.

mass the size of the state of West Virginia. It is located in the states of California, Utah, New Mexico, and Arizona. The Indians have their own government, half Indian and half Anglo, and the same government laws apply on all Indian reservations. They do not pay taxes. Up to 70% of the men are unemployed and collect unemployment allotments, although many of them have taken advantage of the white man's facilities off the reservations and have obtained college degrees. But this education often is useless. Dr. Hallum says he saw pharmacists and some with PhD degrees who were unemployed, both men and women. They are curious about the white man and his ways, he explains, and go away to see how the white man lives. But they usually end up back among their own people.

They have no electricity or running water in their hogans, which are round, single buildings that are economical to run. There are no conveniences. They shun all that.

Each family scratches out a little garden to raise corn and other vegetables. Government stamps, a well-stocked commissary, and free health services are available to them. But they work hard just to live. The women tend the goats and sheep, as well as the crops. They shear the sheep, cart the wool, dye it, spin it, and weave rugs and other items which they sell. Sometimes about 500 hours are spent making one rug. The Hallums bought two of the most beauti-

ful rugs they could find, one 3 by 5 feet in size, the other 4 by 6 feet. The designs are passed down in families and are kept in the communities. There is a college on the reservation run by the Indians who teach these traditional skills.

The biggest expense the Indians have, Dr. Hallum says, is buying gasoline to run their automobiles. Often they will go off the reservation at night to buy alcohol, which is a problem for both men and women. The accident rate at night is high. They have little means of recreation. Only those few who have electricity ever look at television.

While Dr. Hallum was working, Mrs. Hallum spent her days exploring the area, looking at pottery, jewelry, and other arts and crafts produced by the Indians. She found it to be no problem at all driving alone on the reservations during the day.

Dr. Hallum grew up in Atlanta in a medical family. His father, Dr. Alton V. Hallum, Sr., is an ophthalmologist. Dr. Hallum, Jr., was graduated from Emory University in 1958 and from the Emory University School of Medicine in 1962. After serving a rotating internship at Duvall County Hospital in Jacksonville, Florida, he spent 3 years in the Air Force in the Philippines. By that time, he was married and had two school-age children. They enjoyed military life, he says, which gave them a chance to travel. Living was easy. There was a live-in house maid 6 days a week for $20 a week. After returning to Atlanta, he completed his training in obstetrics at Grady Memorial Hospital and has been in practice since 1969.

Mrs. Hallum, the former Elaine Ward of Fitzgerald, was an English major at Emory and is the co-author of several books. The two children are now 19 and 21. The daughter is a nursing student at Vanderbilt and the son is a pre-medical student at Suwanee.

Dr. Hallum sums up his sojourn among the Indians by exclaiming over the longevity of the people. "I saw several women who were in their 90s and some over 100," he says. "They do not worry about time or anything else. If we had their philosophy, we would have much less stress, and we would live longer."

Does he want to re-live his dream after seeing first-hand how the Indians live? With a broad smile, he answers: "Definitely!" What about his wife? "She'd go back tomorrow," he says solemnly, if it were not for responsibilities at home. Maybe later, he concludes.

The Indian Health Service still needs volunteers, he adds. Any obstetrician who wishes to share in a similar experience should contact the American College of Obstetrics in Washington, D. C. For other health specialties in which the need also is great, information may be obtained by writing to the Indian Health Service in Washington.

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No phase of Napoleon's life presents more intense human interest than the final drama enacted on St. Helena during his last illness and death.

The Illness and Death of Napoleon

WALTER R. HOLMES, M.D., *Atlanta**

On May 5, 1821, just one hundred years ago, Emperor Napoleon died, an exile upon the island of St. Helena. Although we may not admire Napoleon, the man, his despotic pride, his insatiable ambition, the many acts of cruelty with which his name is stamped, we cannot help but be fascinated by the history of his life. Napoleon's name fills more pages of the world's solemn history than that of any other mortal. Every phase and incident of his life has furnished material for books dealing with his career and character, his victories and defeats, his views on politics, religion, love, the kind of clothes he wore, the food he ate, and where and when he ate it. No phase of his life, however, presents more intense human interest than the final drama enacted on St. Helena during his last illness and death.

It is pathetically tragic how often Kings and Emperors in the circumstances of their death are less fortunate than their meanest subjects. Macaulay says speaking of the death of Charles II: "The fourteen doctors who deliberated on the King's case contradicted each other and themselves. Some of them thought that his fit was epileptic and that he should be suffered to have his dose out. The majority pronounced him apoplectic and tortured him during some hours like an Indian at a stake. A loathsome volatile salt extracted from human skulls was forced into his mouth. Then it was determined to call his complaint a fever, and to administer doses of bark. One physician, however, protested against this course and assured the Queen that his brethren would kill the King among them."

No less fortunate were the circumstances surrounding the death of Emperor William I of Germany. We see the spectacle of doctors and courtiers crowding about his bed, until the patient, his reason already clouded by the shadow of death, cried out "Zu viel menschen." (Too many people!)

As Louis XIV died, Fagon the physician and Mareschal the surgeon were wrangling over the treatment that should be given the King.



Napoleon I wears the uniform of a general in the Chausseurs of his own Imperial Guard. Some believed him to be a great reformer; others thought him a monster. Friend and foe alike, however, agreed on one point: that as emperor of the French and for 16 years master of most of Europe, Napoleon was one of the greatest military geniuses of all time. The Legion of Honor medal is shown on his lapel above. (From Compton's Pictured Encyclopedia, Vol. 10, 1960; photo courtesy of Mrs. Evelyn Ward Gay.)

* This article is reprinted from the August, 1921, issue of the *Journal*. It was read before the MAG in Rome, GA, in May, 1921. At that time, Dr. Holmes was an instructor in gynecology at Emory University.



To the troops he commanded, Napoleon was known fondly as the "Little Corporal." To the monarchs and kings whose thrones he overthrew, he was "that Corsican ogre." This likeness of him was sketched from life in 1812 by Girodet-Troison. (From *Europe and the French Imperium*, 1799-1814, by Geoffrey Bruun, 1938, Harper and Bros., NY; photo courtesy of Mrs. Evelyn Ward Gay.)

In the death of Napoleon, there is none more tragic in itself and more shameful in its circumstances. Political considerations were largely responsible for the medical treatment which he received. The British government refused to believe almost to the last that the Emperor was critically ill and the medical attendance which was supplied was of the most unsatisfactory kind. His case was never correctly diagnosed. Much of the misconception as to the true nature of the illness of Napoleon arose from the disagreement between the two hostile factions which existed on St. Helena. Dr. Chaplin says "On the one hand, the British government and its instruments were ever anxious to proclaim to the world that Napoleon was in good health and was enjoying, as far as was compatible with his position, the bracing airs and salubrious climate of St. Helena. On the other hand, those surrounding the Emperor insisted that the climate of St. Helena was slowly but surely sapping his strength and that as the result of his residence on the Island chronic hepatitis had laid its hold on him and numbered his days."

Such modern authors, as Lord Rosebery and M. Paul Fremeaux writing at a time when the passions of the period had subsided, have pronounced the verdict that, —

1. In his last illness, Napoleon was attended by a series of incompetent physicians, who formed a wrong opinion of the case and applied disastrous remedies. 2. That Napoleon died of cancer of the stomach, the Emperor himself being the only one to form an approximately accurate diagnosis.

Napoleon's Medical History

Of the past medical history of Napoleon prior to his exile, we have fragmentary knowledge. That Napoleon enjoyed good health during the early period of his life is evidenced by the strenuous life which he lead. His active campaigns, extending over a period of 20 years, in varying climates from the scorching heat of the Egyptian expedition to the extreme cold of the Russian campaign, did not seem to undermine his iron constitution. There are a few interesting facts recorded concerning his past medical history. One peculiarly interesting fact was an habitually slow pulse. Corvisart states that his pulse rarely beat over 50 per minute. Napoleon himself said that he had never been conscious of the beating of his heart and doubted if it did. It has also been recorded that he occasionally had attacks of vomiting followed by lethargy and stupor amounting to actual unconsciousness. These attacks came on usually after prolonged physical exertion, mental strain, and outbursts of temper. Because of these attacks, has arisen the statement that Napoleon suffered from epilepsy.

Dr. Chaplin, who has made a careful study of the medical history of Napoleon, affirms that there is no evidence worthy of the name to support the contention that Napoleon suffered from epilepsy. He says, "Gusts of passion and severe vomiting followed by lethargy are poor facts on which to brand a man with the stigma of epilepsy." Rather, Dr. Chaplin thinks that the slow pulse and occasional attacks of stupor verging on unconsciousness would fit in with our newer conception of cardiac pathology and that probably Napoleon suffered from partial or complete "Heart Block."

It would appear, therefore, that prior to his departure for St. Helena, Napoleon had enjoyed remarkably good health, without any indication of the commencement of the grave disease which five and a half years later was to cause his death.

Island Confinement

Napoleon arrived at St. Helena, on board the "Bellerophon," October 17, 1815. (St. Helena is an island approximately 4x10 miles situated in the South Atlantic ocean off the west coast of Africa.) During his exile at St. Helena, Napoleon was attended by four physicians, O'Meara, a British naval surgeon, Stokoe, the surgeon of the English ship the "Conqueror," Antommarchi, a young Corsican anatomist, and Arnott, British medical officer of the 20th Regiment, stationed at St. Helena. In the limited scope of this paper, it would be impossible to

take up in detail, the development of symptoms and treatments administered by the above mentioned four doctors during their periods of observation of the Emperor. As already intimated, the medical care of Napoleon was not of the best. In defense of the physicians it must be said that Napoleon was a difficult patient to read. He professed a profound disbelief in the art of medicine. Even with such men as Corvisart, he used to maintain that medical care was futile. Every drug administered was obstinately refused and a satisfactory reason demanded for every symptom and every step in the treatment. His faith in medicine was not exalted by the care which he received at the hands of his attending physicians. For example, Antommarchi, a few weeks before Napoleon's death insisted on administering to him ¼ gr. of tartar emetic. The unfortunate patient rolled in agony on the floor. One may well imagine the suffering induced by prolonged wretching in a patient whose stomach was extensively ulcerated by a far advanced carcinoma. Napoleon called Antommarchi an assassin and declared that he would never see him again. His dislike of the Corsican physician was so intense that alone of all his attendants Antommarchi is not mentioned in the Emperor's will.

Political considerations were largely responsible for the medical treatment Napoleon received during his last illness

During the first two years of his exile on St. Helena, Napoleon enjoyed fairly good health. His sedentary habits, however, during this period brought in its train laziness, peevishness, and corpulence. It was not until September 30, 1817 that we have recorded the first symptom pointing to the location of the lesion which was to cause his death. On that day, Napoleon complained for the first time of a dull pain, a heaviness, a sensation of heat in the right hypochondrium and numbness and pain in the right scapular region. From this time to his death Napoleon was never completely free from the symptoms just described.

To quote again from Dr. Chaplin:

"The chief symptoms of the illness of Napoleon previous to its final stage were:

1. Persistent pain situated in the right hypochondrium.
2. Pain, either dull or lancinating in character, fixed in the right scapular region and in the right breast.
3. Nausea and vomiting. Coffee ground vomitus.
4. Constipation at times alternating with diarrhoea.
5. Flatulent distention of the abdomen.
6. Febrile disturbance attended with profuse sweatings.
7. A more or less constant dry cough.
8. Increased pulse rate.
9. Coldness of the extremities.
10. Loss of appetite.
11. Marked and increasing prostration."

Although many of the above mentioned symptoms pointed to a lesion in some part of the alimentary tract, more especially the stomach, none of the physicians in attendance guessed at the true nature of his trouble, but persisted either in their diagnosis of hepatitis or in minimizing the seriousness of the Emperor's illness. Arnott eight days before Napoleon's death assured the British authorities that he was only suffering from hypochondriasis.

Napoleon himself made a shrewd guess at the nature of his disease. His father had died at the age of 39 of cancer said to have been situated in the stomach. The Emperor frequently foretold that he would die of the same disease. Often during his illness he would place his hand over his stomach and say with a groan, "O mon pylore! O mon pylore!"

During the years 1820 and 1821 there was increasing infirmity and accentuation of the symptoms already mentioned. It would be useless to recount the daily reports of the doctors during this period which gives the clinical picture of a patient slowly dying of a malignant disease; emaciation, loss of appetite, obstinate constipation, increased gastric distress, persistent nausea and vomiting. During periods of remissions of symptoms, the Emperor would go for short walks, horse back riding, or amused himself in the cultivation of his garden. However, during most of the time he was confined in his room at Longwood. On April 14 and 15, Napoleon, realizing that his days were numbered, summoned Montholon and Marchand and dictated in clear terms his last will and testament. In addition he dictated the message which should be sent at his death to Sir Hudson Lowe, the British governor of the island whom he so intensely hated.

"Monsieur, the Governor, Emperor Napoleon is dead, after a long and painful illness. I have the honor to inform you.

"He has authorized me to communicate with you and ask that you grant his last wishes. Will you make known what are the regulations prescribed by your government for the transportation of his body to Europe?"

"On April 28, Napoleon talked incoherently and became comatose. On May 4th, the pulse rose to 110, the patient was unconscious, the motions were passed involuntary, risus sardonicus was present, and the eyes were fixed. Napoleon remained in this condition until eleven minutes to six on the evening of May 5th, 1821, when he expired."

Post Mortem Examination

On the day following his death, May 6, 1821, at 3 p.m., the post-mortem examination was performed by Antommarchi in the presence of the surgeons, Shortt, Arnott, Burton, Livingstone, Mitchell, Henry and Rutledge. The dissection was carried out in a green painted and crudely lighted room of Longwood. There are three accounts of the autopsy in existence. The official report drawn up and signed by Shortt, Arnott, Burton, Livingston, Mitchell, Henry and Rutledge, the report of Henry and the detailed and excellent account of the autopsy by Antommarchi.

The following are abstracts taken from the notes of Henry, the Official Report, and from the record written by Antommarchi:

Henry: "The body measured after death 5 feet 10 inches.

"The face presented a remarkably placid expression, indicative of mildness and even sweetness of disposition, which afforded a most striking contrast with the active life and moral character of the deceased. The head was not opened, it was of large size and must have been disproportionate to the body, even in youth. The whole surface of the body was deeply covered with fat. The skin was noticed to be very white and delicate, as were the hands and arms. There was scarcely any hair on the body, and that of the head was thin, fine and silky."

Official Report: "On cutting the thorax, a small adhesion was observed between the left pleura and the pleura costalis. About three ounces of reddish fluid were contained in the left cavity and nearly eight in the right. The lungs were quite normal."

Antommarchi: "The pericardium was healthy in appearance and contained about an ounce of fluid citron in color. The heart which was a little larger than the fist of the subject exhibited, although sound, a more than usual amount of fat at its base and on its ridges. The ventricles and auricles were healthy, but pale and quite empty. The orifices did not show any notable lesion."

Official Report: "Upon opening the abdomen, the omentum was found remarkably fat, and on exposing the stomach the viscus was found the seat of extensive disease; strong adhesions connected the whole superior surface, particularly about the pyloric extremity, to the concave surface of the left lobe of the liver; and on separating these, an ulcer which penetrated the coats of the stomach was discovered one inch from the pylorus, sufficient to allow the passage of little finger. The internal surface of the stomach to nearly its whole extent was a mass of cancerous disease, or scirrhous portions advancing to cancer; this was particularly noticed near the pylorus. The cardiac extremity for a small space near the termination of the esophagus, was the only part appearing in a healthy state. The stomach was found nearly filled with a large quantity of fluid, resembling coffee grounds.

"The convex surface of the left lobe of the liver adhered to the diaphragm, but with the exception of the adhesions occasioned by the disease in the stomach, no unhealthy appearance presented itself in the liver."

Antommarchi: "The bladder was empty and very contracted, containing a certain amount of gravel mixed with definite calculi. Numerous red patches were scattered over the mucous membrane of the bladder and its walls were in a diseased state."

The findings at autopsy of the evidence of a chronic cystitis and calculi in the bladder are of interest as Napoleon was known to have suffered from dysuria which at the battle of Borodino was so severe that riding caused considerable pain and he had to be placed under the influence of opium.

All three reports of the autopsy agreed in assigning the cause of death to carcinoma of the stomach. From the description of the pathological specimens and the duration of symptoms, it seems highly probable that the carcinoma was superimposed on a chronic gastric ulcer.

In the museum of the Royal College of Surgeons of England are two specimens of small intestine, catalogued, "Incipient Fungous in the Glands of the Intestine, Napoleon; Barry O'Meara to Sir Astley Cooper." A great deal of discussion has arisen as to the genuineness of these specimens. O'Meara left St. Helena in 1818, three years before the death of Napoleon. The body of Napoleon was carefully guarded before burial, and it seems highly improbable that any part of his intestines could have been removed. For these reasons, the compilers of the Museum Catalogue express their doubts as to the genuineness of the specimens. Professor Keith, Conservator of the Museum, in a recent paper gives as his opinion that the above mentioned specimens are authentic, and were removed secretly from the body of Napoleon by Antommarchi and given to his friend O'Meara. This point will perhaps never be settled. When examined histologically, these specimens of intestines show the pathological changes found in Malta fever; a hypertrophy of the lymphoid tissues of the body, notably Peyers Patches in the small intestines. If these specimens are genuine, it throws new light on the illness of Napoleon and proves that in addition to carcinoma of the stomach, he may have suffered from Malta fever, the diagnosis made by his attending physicians.

Napoleon was buried on St. Helena, where he remained entombed until Oct. 16, 1840 when the British government performed an act of reparation by giving up the body of the Emperor to its rightful owners, the French nation.

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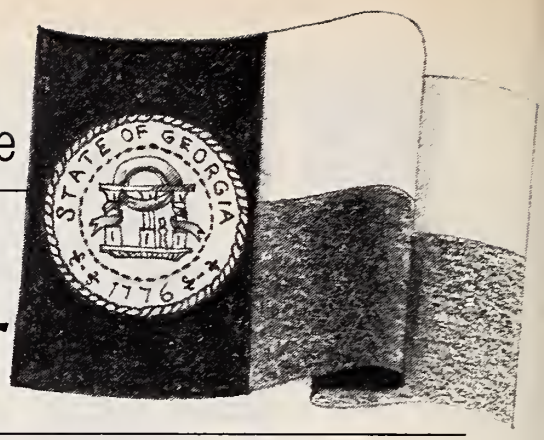
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Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

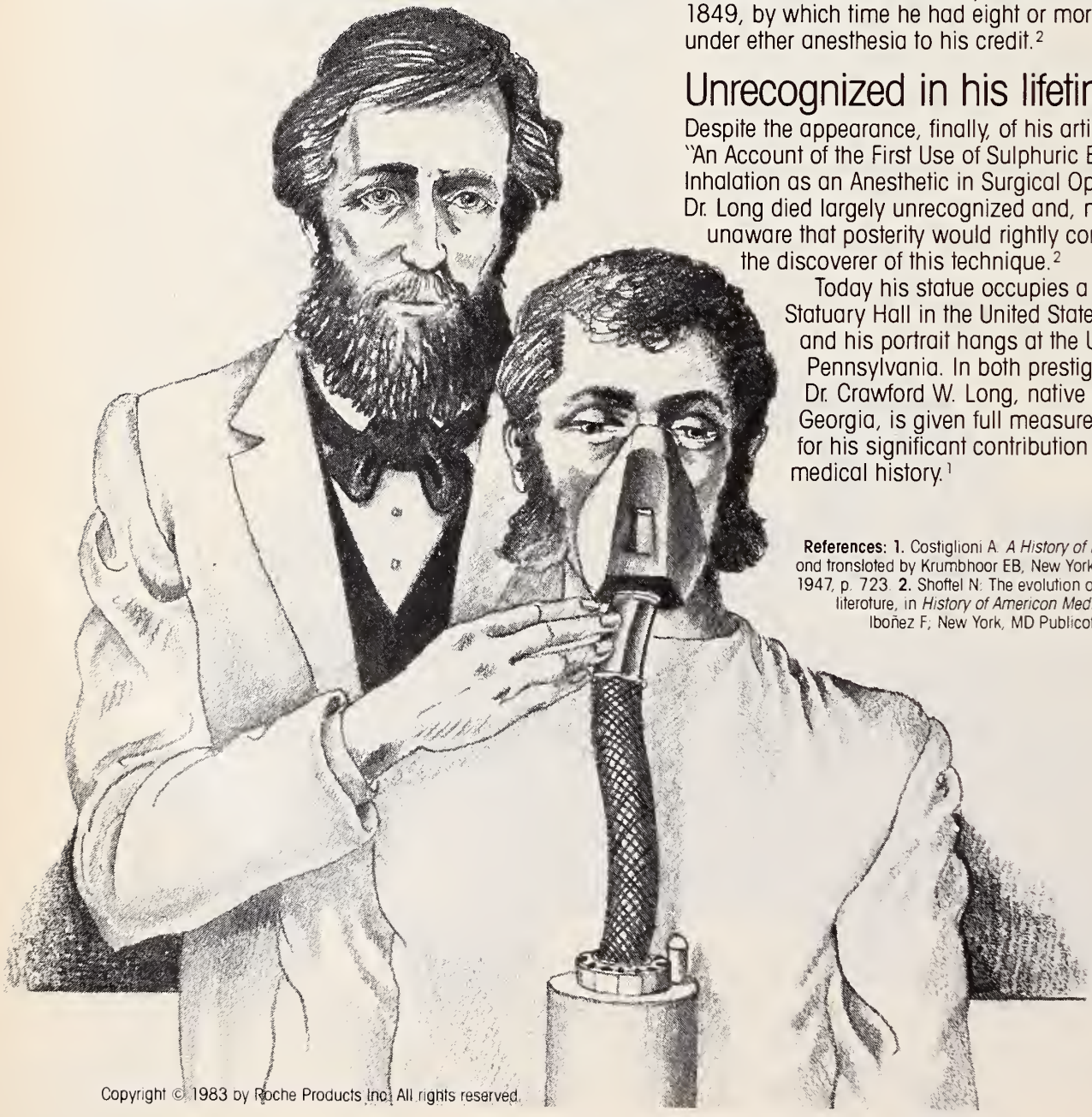
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Costiglioni A: *A History of Medicine*, edited and translated by Krumbhaar EB, New York, Alfred A. Knopf, 1947, p. 723. **2.** Shaffel N: The evolution of American medical literature, in *History of American Medicine*, edited by Morti-Ibañez F, New York, MD Publications, 1959, p. 107.

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References: 1. Rickels K: Drug treatment of anxiety, in *Psychophormocology in the Proctice of Medicine,* edited by Jarvik ME; New York, Appletan-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychopharmocology 61:* 217-229, Mar 1979. **3.** Data on file, Haffmann-La Rache Inc., Nutley, NJ.

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Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and blooting. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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Physiologic or psychologic reactions can occur at a specific time in a person's life in response to some traumatic event which has not been effectively mastered.

Anniversary Reactions With Death

ALFRED A. MESSER, M.D., *Atlanta**

A 44-YEAR-OLD PUBLISHING EXECUTIVE died of coronary thrombosis while playing softball on July 4, 1982. He was in apparent good health; his last physical exam 3 years before had been completely normal, but he had complained of feeling "tired" the day before his death. His father had died the previous year at age 63 while playing softball at the same annual family picnic.

Forty-two-year-old Elvis Presley died August 16, 1977, of "cardiac arrythmia" after a lifelong history of mood swings and drug abuse. Presley's own mother died August 14, 1958, of a heart attack at age 42.

These are two examples of anniversary reactions: physiologic or psychologic reactions which occur at a specific time in a person's life in response to some traumatic event which has not been effectively mastered. Physical symptoms range from headache and muscle ache to peptic ulcer, colitis, and heart attacks. Psychologic symptoms may include recurring nightmares, phobias, depression, and even psychotic episodes. Usually, the sufferers are not consciously aware of the connection between current symptoms and past traumatic events, and by no means are the reactions generally fatal.

Dr. George Pollock, a Chicago psychoanalyst, described an unusual symptom in a woman of 27: depression every afternoon at 5:30 p.m. when her husband came home and turned the lock with his key. During analysis, it was discovered that the patient's father died suddenly when she was 13. She was never able to mourn his death, and had a recurring fantasy of "waiting at the door" for his return.[1]

Sigmund Freud wrote extensively about anniversary reactions, although he did not use this terminology. In the concept of repetition compulsion (1920), Freud suggested that an individual makes repeated, and often self-defeating, attempts to master a traumatic situation that was so intense it could not be mastered at the time it occurred. One of Freud's early patients "celebrated annual festivals of remembrance at the point of her various catastrophes . . . which kept to the date precisely."

Some Anniversary Symptoms

Work-centered individuals may experience symptoms, usually depression, on Sundays or holidays. These are people who use work to suppress painful impulses that emerge if he or she feels "lazy and unproductive." And then there are the Thanksgiving and Christmas haters who react to those holidays with depression, moodiness, and irritability. They see people around them experiencing joy and intimacy, in sharp contrast to their own childhood memories of family combat and disruption.

We occasionally see symptoms in a parent whose child reaches the age at which the parent experienced a significant trauma. A 28-year-old woman developed severe colitis when her daughter reached age 5; the mother had been separated from her own mother when she was 5.

Sometimes parents of dating adolescents who periodically stay out beyond parental curfews can unleash accusations that their child is a "sex fiend" or "tramp." The youngster's behavior may not warrant such an outburst; rather, the behavior reawakens unresolved conflicts about sex in the parents' own adolescence.

Manic-depressive patients who suffer recurring attacks of depression may, under careful study, turn out to be people with recurring anniversary reactions. People who go through periods of grief frequently have stomach pains or intestinal upset. I believe this represents a conditioned response to an early and recurring sense of loss — namely, the daily

* Dr. Messer practices psychiatry and psychoanalysis at Northside Hospital. Send reprint requests to him at 801 Douglas Rd., NE, Atlanta, GA 30342.

separation of an infant from the arms of a nourishing mother. Think for a moment of watching a dramatic scene in which two people part. The emotion causes us to feel a lump in the throat, and as we swallow, there's a sense of tightness down the center of the chest.

The study of anniversary reactions allows us to connect Freud's psychologic theories with Pavlovian theories of conditioning: not only does the mind confront unresolved trauma, but the body reacts to this trauma with conditioned response.

And who knows the range of highly personal reactions on significant dates? Three of our first Presidents died on July 4. Two of them were Declaration of Independence signers who died on its 50th anniversary.

Preventing Attacks

How do we prevent pathologic anniversary reactions? First and foremost, by recognizing their occurrence. We always retain memories of traumatic events, and talking these out with family, friends, or physicians helps resolve subconscious conflicts and heal old wounds. I encourage people to buy a calendar with month-at-a-glance pages. If they carefully circle those days on which significant traumas occurred in the past, such as the day a loved one died, a house burned down, a company folded, or a political election was lost, they are consciously prepared for possible anniversary reaction.

In our culture, men who reach age 50 and women who attain the age of 35 may be depressed on those birthdays; they are mourning their lost youth.

Since anniversary reactions are often related to unresolved grief over the death of a loved one, we try to help survivors complete the mourning process. Young children who lose a parent need to express their fears and despair over the loss, as well as the anger at feeling abandoned. Although we are enjoined to "speak kindly of the dead," it may be more psychologically appropriate to "speak truthfully of the dead."

When parents lose a child unexpectedly, they should actively participate in the funeral — even to the extent of dressing the child and combing his or her hair for the last rites. In this way, the fact of death is acknowledged, and the mourning process is assisted. We should also encourage built-in remembrances: memorial days, anniversary masses, Kaddish each year on the anniversary of death, etc.

So widespread are unrecognized anniversary reactions that some forms for medical history-taking now contain a line: "What is the special significance of this day in the patient's life?" Indeed, Dr. Jesse Cavenar of Duke University, who has written extensively on anniversary reactions presenting as physical complaints, states " . . . with the onset of *any* physical or emotional problem which is not readily explainable by current life circumstances, the possibility of an anniversary reaction should be entertained."[2]

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1. Pollock GH. Temporal anniversary manifestations: hour, day, holiday. Psychoanal Q 1971;40:123-131.

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editorial
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Annual Session in Columbus

The Muscogee County Medical Society, the Auxiliary to the Muscogee County Medical Society, and the city of Columbus extend to you a special invitation to attend the 129th Annual Session of the Medical Association of Georgia.

MAG has met in Columbus on three occasions, 1892, 1960, and 1966. We believe you will find a vast improvement in the meeting facilities since your last visit. There are many things of which we are proud, and one is the Columbus Iron Works Convention and Trade Center site of this meeting. One quiet stroll through the facility can only inspire awe. There are large, spacious areas and smaller cozy areas. But the truly remarkable aspect is the dignity of this beautiful building as it stands on the banks of the Chattahoochee, a silent testament to a city's respect for its past and hopes for the future.

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The Case for Community Chemotherapy

C. B. FUTCH, M.D., *Brunswick**

THE IMPACT OF CHEMOTHERAPY in the area of oncologic modalities during the past 5-10 years is immeasurable. The concept of multimodal cancer therapy embracing all the important areas of nutritional support, physical therapy, and the psychologic impact on patient and family has proven its worth. No longer does the chemoimmunotherapist bring immediate visions of the last resort "grim reaper" as he did during the late sixties and early seventies. His ascendency was difficult but well deserved.

It is now proper to take chemotherapy back to the community. Yes, in spite of the moans and groans of the multiple oncologic groups of our many universities, without which we would have little if any meaningful treatment protocols, the time is *now* if we are to continue to achieve success.

Who cannot remember the movement of vascular surgery to the community hospital? The condemnation and consternation of University Vascular Services was universal — some still persists. Yet vascular surgery is now commonplace throughout the U.S. Carotid endarterectomy, axillofemoral bypass grafts, etc., are being done not only by those surgeons fully trained in that surgical subspecialty but also by others who 10 years ago did not even know the basic types of vascular clamps available. It is apparent that the excellent training provided by university vascular surgeons was responsible for its demise as a "large hospital only" commodity. Cardiac surgery will eventually follow suit. Chemotherapy should also.

The only tools necessary for adequate community chemotherapy care are physician interest (surgical/medical, or both), an adequate lab, a radiotherapist with necessary equipment, and support groups such as a nutritionist, a physical therapist, and hospice-type psychologic support. Although a tumor board and registry are not necessary, certainly they are helpful in providing guidelines and assuring persistent patient follow-up and accurate record keeping.

Care of Cancer Patients

The reasons that chemotherapy should be a community effort are quite obvious to those involved in cancer care. Cancer has an impact not only on the patient but the entire family. To ensure continuity of care, emotional support, and comfort for the family, the family physician, operating surgeon, and therapists should ideally know the patient and family intimately. Since the family physician knows the patient well, and the surgeon has often cared for the patient during hospitalization for major surgery, they can better judge the intensity of chemotherapy treatment

* Dr. Futch practices general surgery. Send reprint requests to him at 2432 Parkwood Drive, Brunswick, GA 31523.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

that will be tolerated. The thought of travel to a "center" for therapy is both devastating psychologically and financially to the patient and family. Often, in a limited time span situation, valuable "good" days are lost in travel, motel living, and worry. Often, those people occupying a position of trust are unable to comfort the patient and are not present during difficult times or at the time of death. In addition, the community physician is often confronted with complications of therapy he knows little or nothing about. His insecurity is obviously reflected to the family and patient with the end result of an unhappy physician, patient, and family.

Steps should be taken now by investigative centers to provide education, information, and open lines of communication to encourage the use of "at home" chemotherapy. Seminars, bulletins, and oncologic groups available to the community physician are necessary. Lines of communication must be established to encourage conformity, follow-up, and awareness of therapeutic goals.

The University oncology department's contributions to the knowledge and growth of the specialty cannot be denied. Indeed, it is to be praised, encouraged, and supported. However, we must not forget that the patient and family remain paramount. It is ultimately for them that research centers exist. In spite of objections, and there will be many valid ones, the transition must come.



heart page
heart page
heart page

Dental Treatment of Cardiac Patients

MARK A. PADOLSKY, D.D.S., *Atlanta**

THE PRIMARY BATTLE a dentist wages in the treatment of his/her patients is against fear, regardless of how painless a procedure might be. With a cardiac patient, it is especially important to reduce the psychologic and physiologic stress associated with a dental visit so that an anginal episode or myocardial infarction is not precipitated. Therefore, it is important for the physician and dentist to plan for these visits. The American Heart Association has stressed that "there is need for mutual understanding, respect, and cooperation between physician and dentist in the best interest of the patient to be served." This article is written in that spirit.

A stress reduction protocol is highly recommended, even beginning the previous evening. Sleeping medication may help provide a rested patient who can more easily resist challenges. Pre-sedation can reduce anxiety, as can the use of early morning appointments which minimize the length of time the patient has to worry about the upcoming work. Short appointments with the use of nitrous oxide analgesia assure a comfortable patient. Certainly adequate depth of anesthesia is essential, as the sudden onset of pain can be devastating. Post-appointment sedation may also be helpful.

The use of epinephrine in an anesthetic solution is rarely contraindicated. Remembering that our primary problem is fear, certainly any sudden pain might trigger an episode. Epinephrine provides the local vasoconstriction needed to obtain profound and lasting dental anesthesia. The amount of epinephrine released systemically is minimal with proper injection technique (i.e., proper placement and aspiration), especially in comparison to the amount of endogenous catecholamines that may be released with sudden pain. However, epinephrine in dental retraction cord is used at a much higher concentration, and it should be avoided with the cardiac patient.

The average American routinely sees his dentist more often than his physician. For this reason, many dentists are utilizing an extensive medical history as well as taking blood pressure, pulse and respiration rates of new patients. This should be done periodically on identified cardiac patients. Inquiries concerning chest pain duration, strength, and frequency should be made. If any change occurs, the patient should be referred to a physician immediately.

When appropriate, nitroglycerine or other medications should be brought to the dentist's office by the patient. If the need arises, these probably will be fresher than those in the dentist's emergency kit. If there is any chance of bacterial endocarditis, administration of prophylactic antibiotics is encouraged. The dental appointment

* Send reprint requests to Dr. Padolsky at 401 Peachtree St., NE, Ste. 800, Atlanta, GA 30308.

Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

should be terminated immediately and the patient observed closely if any signs of distress develop. The office staff should be trained in CPR, and the emergency kit and numbers should be readily accessible.

Regular, preventive dental care is important in all cases, but is especially important for compromised patients. A dental problem which is identified early is usually an easier and more pleasant one to solve. Cardiac patients can enjoy a positive dental self-image and a life free of dental caries and pain with some modification in regular dental treatment.

References

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Georgia's Medical Malpractice Statute of Limitations Declared Unconstitutional as Applied to Wrongful Death Actions

ROBERT N. BERG, *Atlanta**

GEORGIA'S MEDICAL MALPRACTICE statute of limitations[1] was enacted in 1976 for the purpose of designating certain specific limitations on the period of time within which claims may be brought for damages resulting from the death of or injury to any person caused by medical malpractice. Since its enactment, this statute has been the subject of several Legal Pages: first, when the Georgia Supreme Court upheld the constitutionality of the distinctions made by the legislature (i) between medical malpractice plaintiffs and other plaintiffs, and (ii) between "general" medical malpractice actions and malpractice actions where a "foreign object" was left in a patient's body; and, subsequently, as the Georgia courts struggled with difficult questions involving the interpretation and applicability of the medical malpractice statute of limitations in specific factual situations.

Inasmuch as the Georgia Supreme Court, on 2 separate occasions, had upheld the constitutionality of the Georgia medical malpractice statute of limitations,[2] it seemed clear that defendants, in moving to dismiss medical malpractice claims on the grounds that the applicable statute of limitations had run, could rest assured that plaintiffs could not circumvent those challenges by successfully contending that the statute of limitations infringed upon their constitutional rights. All was not as it seemed, however, as the Georgia Supreme Court, in a recent case, declared the medical malpractice statute of limitations unconstitutional as applied to wrongful death medical malpractice actions.

Medical Malpractice Statute of Limitations

First, a short refresher course is in order on the basic principles of medical malpractice statutes of limitations. Generally, a statute of limitation imposes a deadline upon the time within which a plaintiff may file a cause of action; if the lawsuit is not filed within the applicable period of time, the plaintiff is forever barred from filing the lawsuit. Statutes of limitations serve to effectuate certain well-recognized public policies — requiring that a defendant be put on notice of a claim within a reasonable period of time and, ultimately, protecting defendants against the prosecution of "stale" claims. As described by the Georgia Supreme Court:

> "Statutes of limitation, by their very nature, bar access to the courts after the prescribed period of time has elapsed. 'Statutes of limitation . . . in their

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

conclusive effects are designed to promote justice by preventing surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded, and witnesses have disappeared. The theory is that even if one has a just claim it is unjust not to put the adversary on notice to defend within a reasonable period of limitation and that the right to be free of stale claims in time comes to prevail over the right to prosecute them.' ''[3]

Georgia's medical malpractice statute of limitations applies these public policy considerations specifically in the context of medical malpractice cases. Because the injury arising out of an act constituting medical malpractice oftentimes may not be apparent for many years, medical malpractice plaintiffs challenging the professional diagnostic judgment or discretion exercised by a physician are required to institute their claims within a fixed period of time (2 years) *following the alleged wrongful act*. This differs from the statute of limitations applicable in actions other than malpractice cases, in which the lawsuit must be filed within a fixed period of time *from the date upon which the plaintiff learned or should have learned of the wrongful act*.

In enacting the medical malpractice statute of limitations, the Georgia General Assembly, in effect, was not making new law; it was not declaring that a *different* time limitation be applied in medical malpractice cases. Rather, the medical malpractice statute of limitations constituted a legislative mandate regarding the time at which a medical malpractice cause of action ''accrues'': in non-malpractice cases, the cause of action ''accrues'' at the time the plaintiff learns of the negligent or wrongful act, and runs for a period of 2 years; on the other hand, in medical malpractice cases, the cause of action ''accrues'' at the time of the negligent or wrongful act, regardless of whether or not the plaintiff was aware of the existence of the act at that time, and runs for a period of 2 years. As will be seen below, the concept of ''accrual'' of a cause of action can be quite significant.

Applying Georgia's Medical Malpractice Statute of Limitations in Wrongful Death Cases

In the case recently decided by the Georgia Supreme Court, *Clark v. Singer*,[4] the plaintiff instituted, in June, 1981, a wrongful death action against two physicians and their professional corporation. The plaintiff was the widow of a patient who died in June, 1979, due to carcinoma to the lung with metastasis and other related contributing conditions. The plaintiff's lawsuit was grounded upon her allegation that the treating physicians had failed to diagnose and treat her husband for carcinoma of the lungs prior to June, 1978.

Applying the medical malpractice statute of limitations, the trial court granted the defendants' motion for summary judgment and dismissed the action. In the trial court's view, the action — since it was based upon a malpractice claim — should have been instituted prior to June, 1980, the end of the 2-year period commencing on the date upon which the alleged malpractice occurred. Since the lawsuit was not filed by the plaintiff until June, 1981, the medical malpractice statute of limitations had run and the defendants were entitled to summary judgment.

The plaintiff appealed the trial court's decision, claiming that the application of the medical malpractice statute of limitations constituted a denial of equal protection and due process and violated certain other provisions of the United States and Georgia Constitutions. The Georgia Supreme Court agreed.

As expected, the defendants first raised the contention that the Supreme Court, on 2 previous occasions, had upheld the constitutionality of the medical malpractice statute of limitations against due process and equal protection challenges. While the Supreme Court acknowledged its prior decisions, it also noted that both cases involved claims for *injuries* arising out of alleged malpractice, unlike the case before it, in which the plaintiff sought damages for the *wrongful death* of her husband caused by the alleged malpractice. Moreover, the Court stated that, in the

prior cases, it merely found "that the classification of medical malpractice actions separately from other tort actions for statute of limitations purposes was a rational exercise of legislative power."[5]

In *Clark*, however, the Supreme Court viewed the plaintiff's constitutional challenge on a different footing: The plaintiff was not challenging the distinction between medical malpractice plaintiffs and other plaintiffs, the distinction previously upheld by the Court; rather, the plaintiff was challenging the distinction created by the medical malpractice statute of limitations, based upon the date of the death of the patient, with regard to plaintiffs claiming damages arising out of the wrongful death of the patient caused by malpractice. This distinction was explained by the Court as follows:

> "A cause of action for wrongful death caused by another arises in the spouse and/or children or parents of the deceased upon the death of such deceased. The statute of limitations for wrongful death actions other than medical malpractice actions is 2 years, and it runs from the date of death, not the date of the injury or negligent act. . . . Thus, a tortfeasor other than a medical practitioner who injures a person who survives the accident for a lengthy period and later dies from the injuries received can be sued for wrongful death more than 2 years after the date of the negligent act. . . .
>
> As applied to wrongful death actions, [the medical malpractice statute of limitations] creates 2 classes of wrongful death claimants in medical malpractice actions: (1) those whose spouse, child or parent died within the 2 years of the negligent or wrongful act or omission, and (2) those whose spouse, child or parent died more than 2 years after the negligent or wrongful act or omission. Those in the former category can maintain an action for wrongful death, whereas those in the latter category are barred by the statute of limitations before death occurs, i.e., before their cause of action for wrongful death accrues."[6]

Analyzing this distinction under traditional constitutional principles, the Court found that the distinction between wrongful death plaintiffs and other medical malpractice plaintiffs was unreasonable, arbitrary, and did not "rest upon some ground of difference having a fair and substantial relation to the object of the legislation, and therefore unconstitutional."[7] In the court's opinion, the purpose behind the enactment of statutes of limitations — to promote justice by preventing surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded, and witnesses have disappeared — simply was inapplicable in a wrongful death case, since the plaintiff's cause of action for wrongful death in practice could not accure until such time as the patient died. As stated by the Court:

> "A claim which has not arisen has not been slumbering and is not stale. Plaintiff had no opportunity to put defendants on notice as required by law; i.e., by filing suit, within the period of limitation. We find no rational basis for a limitation scheme which permits a medical malpractice wrongful death action if the patient dies within 2 years of the defendant's negligent act but which bars a wrongful death action if the patient lives for 2 years after defendant's negligent act where the defendant is a doctor but not in other wrongful death cases. To impose a limitation period which may be exhausted before the cause of action accrues (i.e., before the patient dies), arbitrarily distinguishes between wrongful death, medical malpractice plaintiffs."[8]

Accordingly, the Court held the medical malpractice statute of limitations to be unconstitutional as applied to actions for wrongful death and, as a result, that the general statute of limitations was applicable. Since the plaintiff had filed her lawsuit within 2 years from the date of her husband's death, her claim was not barred, and the defendants' motion for summary judgment should have been denied.

Conclusion

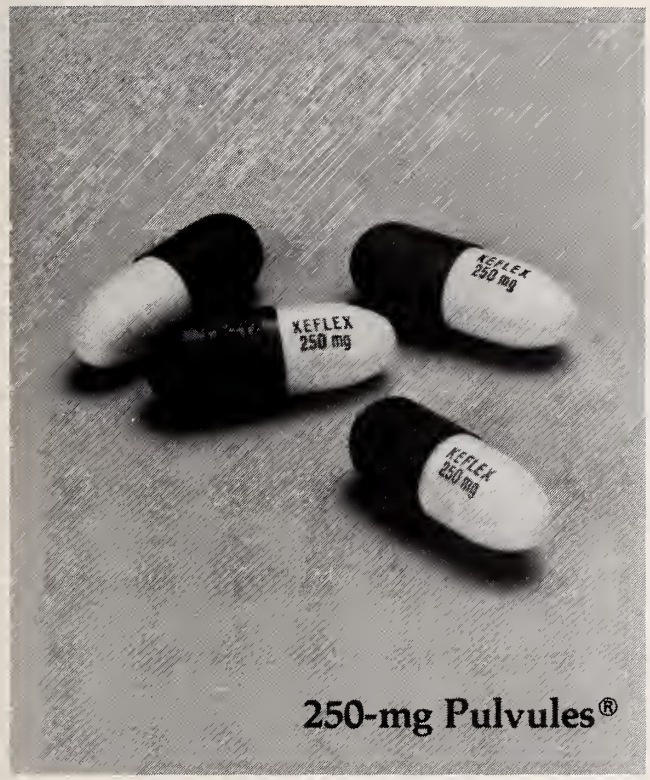
On its face, the Supreme Court's decision in *Clark* is appealing in its simplicity. It is easy to comprehend the unfairness of a statute of limitations which, prior to the time that the right to bring a lawsuit even accrues, would serve to bar that lawsuit, and thereby prevent a widow from recovering for the death of her husband allegedly caused by the defendant physicians' malpractice. At the same time, the *Clark* decision appears to create a new distinction having the potential for equally arbitrary, unfair results: it is constitutionally permissible for the legislature to impose a fixed time period upon the institution of malpractice cases (i.e., 2 years from the date of the wrongful act), as long as the patient only is injured as a result of the alleged malpractice, because of the legitimate public policy in protecting malpractice defendants against stale claims; however, that same limitation is not permissible if the patient dies as a result of the alleged malpractice, even though the malpractice claim may have been barred by the statute of limitations while the patient was alive.

Thus, the Supreme Court appears to have removed the distinction between wrongful death plaintiffs generally and wrongful death plaintiffs in medical malpractice cases, but only at a significant cost to malpractice defendants. In the future, physicians must be concerned with the possibility of being sued for malpractice not only during the initial 2-year period following the date of the alleged negligent or wrongful act, but for an indefinite time thereafter should the patient ultimately die as a result of the malpractice.

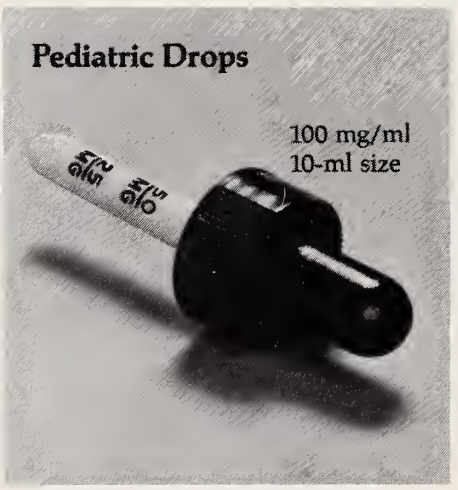
Notes

1. O.C.G.A. §9-3-70 *et seq.*
2. See, *Hamby v. Neurological Associates, P.C.*, 243 Ga. 698 (1979); *Allrid v. Emory University*, 249 Ga. 35 (1982).
3. *Allrid v. Emory University, supra*, 249 Ga. at 39, quoting *Order of Railroad Telegraphs v. Railway Exp. Agency*, 321 U.S. 342, 348-49 (1943).
4. Fulton County Daily Report, *Appellate Court Opinions*, January 11, 1983, at pp. 2-3, _____ Ga. _____ (January 4, 1983).
5. *Clark v. Singer, supra*, _____ Ga. at _____.
6. *Id.*
7. See, *Reed v. Reed*, 404 U.S. 71, 76 (1971); *Allrid v. Emory University, supra*, 249 Ga. at 38.
8. *Clark v. Singer, supra*, _____ Ga. at _____.

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president's letter



Working Together — MAG and the Deans

FOR MUCH TOO LONG, the academic community has felt that its mission is a lofty one, confined to study, teaching and research. Involvement in medical politics and socio-economics could only detract from the quality of the educational atmosphere. This attitude was so pervasive throughout university centers that it was passed along subtlely to the students and residents, to the end that such activities were considered to be demeaning to the dedicated young doctor.

Times have changed. It is clear to those in educational institutions and to practitioners in the communities that we all share many problems and interests. We must all deal with the government, with competition, with society's rebellion against the rapid rise in medical costs, and with the malignant threat of malpractice suits.

MAG has asked for a closer working relationship with the medical schools, and the deans of Georgia's four schools have responded. An MAG Council of Deans has been formed and is meeting regularly. The deans have been attending MAG Executive Committee and Board Meetings and have participated in caucuses with the AMA Delegation at the national meetings. Faculty members are being added to the MAG committees.

Significant joint activities have already been put in motion:

1) More intensive public education activities are being developed with the help and resources of the schools;
2) Cost awareness will be receiving increased emphasis in the teaching of students and residents;
3) Closer collaboration is being planned in working with the legislature on matters significant to medicine;
4) The deans are being consulted on matters related to the Business/Medicine Coalitions;
5) Expanded programs providing quick medical consulting services to physicians in remote areas are being considered.

The work has begun. The partnership is alive. We know that we are in this world of medicine together. Mutual benefits to be realized through closer working relationships between MAG and the medical school deans are already very apparent.

Charles D. Hollis, Jr., M.D.

Charles D. Hollis, Jr., M.D.

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PERSONALS

First District

Anthony M. Costrini, M.D., of Savannah, has attained Fellowship status in the American College of Chest Physicians.

Third District

Jack C. Hughston, M.D., of Columbus, received the 1982 Distinguished Service Award presented by the Georgia Hospital Association. The awards are presented annually to individuals for their outstanding community leadership, professional attainments, concern for quality health and hospital care, and promotion of community health. Dr. Hughston is an orthopedic surgeon known as the primary force and developer of one of the nation's leading orthopedic clinics specializing in athletic injuries. He was a pioneer in the field now known as "sports medicine." In 1976, he was named "Mr. Sports Medicine" by 350 of his colleagues, and in 1977, *Sports Illustrated* called him one of the world's top three surgeons in his field. In 1976, Dr. Hughston founded "The Institution of Athletic Health Care, Inc.," which now supervises, without charge, the screening of every high school athlete in every sport in three Georgia counties and two counties in Alabama. He was a principal developer of the Columbus Crippled Children's Division of the Georgia Department of Public Health. He is the founder of the Hughston Sports Medicine Foundation, which provides continuing education in sports medicine for physicians, coaches, trainers, athletes, physical therapists and the public, with emphasis on injury prevention.



GHA's 1982 Chairman, Jack Whelchel (left) presents a Distinguished Service Award to Dr. Jack Hughston.

Fifth District

Atlanta physician, **Bernard S. Lipman, M.D.,** was acknowledged at Grand Rounds, Grady Memorial Hospital, on December 14, 1982, for his many years of teaching at Emory University Medical Center as a member of the Voluntary Faculty. **J. Willis Hurst, M.D.,** presented Dr. Lipman with a certificate signifying his appointment to Clinical Professor Emeritus, Emory University School of Medicine.

The following Atlanta physicians attained Fellowship status in the American College of Chest Physicians during 1982: **Nestor R. Carabajal, M.D.; Bernard H. Palay, M.D.;** and **Thomas F. Smith, M.D.**

Sixth District

Charles A. Lanford, M.D., of Macon, was elected to office in the Georgia Academy of Family Physicians. **John N. Tripp, M.D.,** a professor of family medicine at the Mercer University School of Medicine, recently was elected chairman of the Commission on Education for the Academy.

John M. Kessinger, M.D., of Macon, attained Fellowship status in the American College of Chest Physicians in 1982.

Seventh District

Mark L. Lipman, M.D., of Carrollton; **Drayton M. Sanders, M.D.,** of Dalton; and **Trammell Starr, III, M.D.,** of Rome, became Fellows in the American College of Chest Physicians in 1982.

Ninth District

Gainesville physician, **John W. Garland, III, M.D.,** was recently elected to Fellowship in the Southern Psychiatric Association, an Honorary Fraternity of Southern Psychiatrists. Dr. Garland practices psychiatry and psychotherapy in Gainesville, where he has served as President of the Hall County Medical Society.

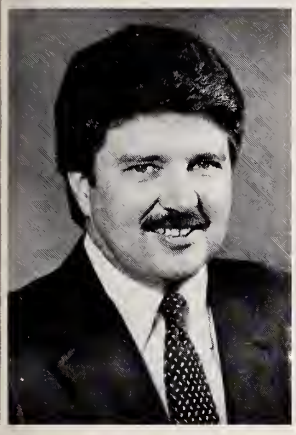
Tenth District

Ronald F. Galloway, M.D., of Augusta, has attained Fellowship status in the American College of Chest Physicians during 1982.

Sophia Boyd Bamford, M.D., was named the 1982 Wilkes County Citizen of the Year for her many contributions to the citizens of Wilkes County. Since 1973, Dr. Bamford has served various terms as a director of the Georgia division of the American Cancer Society. During the ceremony, she was cited for her outstanding community service. In 1981, Dr. Bamford received a community leader award for community service from the state of Georgia.

SOCIETIES

The Georgia Medical Society recently elected the following officers for 1983: **John B. Rabun, M.D.,** president; **Robert B. Quattlebaum, M.D.,** president-elect; **J. Patrick Evans, M.D.,** vice president; **Roderick L. Guerry, M.D.,** secretary; **Ronald S. Summers, M.D.,** treasurer; **A. Preston Russell, M.D.,** historian; and **Dan H. Willoughby, M.D.,** parliamentarian.



Bob G. Lanier, M.D.



Linton H. Bishop, M.D.

The Medical Association of Atlanta, installed new officers for 1983 at its annual banquet held recently. **Bob G. Lanier, M.D.,** was installed as president and **Jeffrey T. Nugent, M.D.,** as president-elect. Also at the banquet, **Linton H. Bishop, Jr., M.D.,** was named recipient of the Aven Citizenship Cup, the Association's highest award, for outstanding community service. Distinguished Service Awards were presented to **Charles D. Hollis, Jr., M.D.; Bob G. Lanier, M.D.; Carter Smith, Jr., M.D.;** and **William B. Anderson, M.D.** Three members of the Association received certificates in recognition of 50 years in the practice of medicine. They are: **Needham B. Bateman, M.D.; William Amos Kelley, M.D.;** and **Fred F. Rudder, M.D.**

DEATHS

Thomas L. Ross, Jr.

Thomas L. Ross, Jr., M.D., a retired practitioner of cardiology and internal medicine, died January 24 after a brief illness. Dr. Ross was 75. He was in private practice in Macon from 1935 through 1969 except for service in the U.S. Army Medical Corps from 1942 to 1946. He graduated from Mercer University and from Emory University School of Medicine. He was associate director of the Georgia Regional Medical Program from 1969 to 1976. He served as president, chairman of the board, and vice president of the Georgia Heart Association and as a director of the American Heart Association. Dr. Ross was also a consultant in cardiology at the Veterans Administration Center in Dublin, a cardiologist of Macon Hospital from 1947 to 1969, and chief of staff of Macon Hospital in 1951-52. He was president of Bibb County Medical Society in 1954-55. He was named a Fellow of the American College of Physicians and a Diplomate of the American Board of Internal Medicine in 1939. He received a number of awards from the American Heart Association, and the Heart of the Year Award of the Georgia Heart Association in 1975.

Survivors include his wife, two daughters, one sister, and four grandchildren.

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Highlights — MAG Board of Directors — January 8, 1983

Chairman of the Board

Jack Raines, M.D., Chairman of MAG Board of Directors introduced George Chastain, M.D., Chairman of the Composite State Board of Medical Examiners who addressed the Board. Dr. Chastain reported on the internal working of the CSBME and the difficulties in processing claims and cases resulting from fraud, unethical practices of medicine, quality of care, drugs, and alcohol.

Auxiliary to the MAG

Auxiliary President, Mrs. David C. (Barbara) Thibodeaux, reported on the activities of the Auxiliary and stated that the President of the Texas Medical Association Auxiliary will visit Atlanta to view the AMAG's "Learning Center," with the view to adopt a similar program for the TMA Auxiliary. The MAG Board saw the "Learning Center" at its June, 1982 meeting.

Mrs. Thibodeaux also reported that Mrs. Brit B. (Evelyn Ward) Gay, Jr., was writing a history of the medical profession in Georgia, a 400-page book which will be published in the fall of 1983.

President's Report

At the May, 1982, Executive Committee meeting, Dr. Hollis appointed Dr. Rhodes Haverty to undertake a project to update the MAG "Quick Reference Guide" and other MAG policies and position statements so they could be computerized for easy reference. Dr. Haverty suggested that MAG needs three different kinds of reference guides, namely, (1) an MAG public policy reference guide; (2) a guide on legislative positions on a variety of issues; and (3) an administrative policy guide.

Dr. Haverty presented a compilation of present policies which he felt would fit the first category and recommended that each be reviewed by the appropriate MAG committee to determine whether or not they should be retained, revised, or repealed. He also recommended that a "Sunset" provision, to allow all policies to be reviewed on a regular basis, be presented to the 1983 House of Delegates. The Board voted to refer the attached policy statements to appropriate MAG committees requesting that recommendations to either maintain, update, amend, or delete be brought back to the April Board for approval.

The Board also voted to store the updated policies in the MAG computer and to review on an annual basis, with the Board recommending to the House of Delegates, that a "Sunset" Provision be adopted so that each year policies are either terminated, reaffirmed, or revised.

State Support for Resident Education

After an address by James Glenn, M.D., Dean of Emory University School of Medicine, the Board voted to assist the newly formed committee for Georgia's Public Teaching Hospitals by lobbying the Georgia Legislature to increase state grants to $10,000 for residents in the six vitally important hospitals.

Report of the Secretary

The Health Policy Agenda for the American People, established by the AMA House of Delegates, to provide a broad-based outline of major concerns for the health sector, including both private and public elements, was brought to the Board's attention by the Secretary, Dr. William D. Logan, Jr. Dr. Logan stated that this conceptual and philosophic framework will be consistent over a multiple-year period as the basis for specific action plans responding to the social, economic, scientific, educational, and political circumstances that evolve from year to year. He further stated that the AMA was asking each state medical association to appoint a member from that state to serve on an Advisory Committee to HPA. Dr. Logan nominated Dr. Edwin C. Evans, of Atlanta, to serve as MAG's representative. The Board unanimously approved.

Executive Director's Report

The Board approved sending two representatives from the newly formed MAG Hospital Medical Staff Section to the AMA/AHA cosponsored conference entitled, "Executive Briefing for Hospital Medical Staff Leadership."

The meeting, to be held in Scottsdale, Arizona, March 3-4, 1983, will offer representatives of the Hospital Medical Staff Section insight into present problems and how best to deal with them on both the national and state levels.

Committee and Department Reports

Professional Liability Insurance Committee — William W. Moore, M.D., Chairman, reported on an investigation of Tort Reform Legislation to set limits on pain and suffering. Dr. Moore stated that several states had enacted such legislation and several others had had such legislation declared unconstitutional. The Board referred the matter back to the committee for further study.

Ad Hoc Committee on Specialty Society Representation — The 1982 MAG House of Delegates created this committee to study the feasibility of Specialty Society Representation in the House and report its findings to the Board, which in turn would report back to the 1983 House. William W. Moore, M.D., Chairman of this committee, gave a lengthy report of the committee's findings to the Board. The committee recommended that each specialty recognized by the MAG Interspecialty Council be given one voting delegate and alternate to represent it in the MAG House of Delegates. The Board voted in favor of this and will ask the Constitution and Bylaws Committee to prepare the necessary amendments to be presented to the 1983 House of Delegates for final approval.

Cancer Committee (Georgia Medical Consent Law) — A. Angier Wills, M.D., presented a report from the Cancer Committee recommending that MAG adopt a policy on Informed Consent for the purpose of opposing attempts at the passage of an ill-advised and/or highly restrictive special purpose law such as the one being proposed in the 1983 Georgia General Assembly and passed in a few other states. Contingent on approval of MAG legal counsel, the Board unanimously adopted the following policy on "Informed Consent":

> "The Medical Association of Georgia strongly supports the concept that the physician is obligated fully and carefully to inform his/her patient of the nature and prognosis of the disease from which the patient suffers.

the choice of therapies which might help, the relative risks and benefits of such therapies, and the physician's own recommendation. The Informed Consent process should not be restricted by any stereotyped lists since these would be incomplete due to the complex nature of a patient and his/her disease process. The physician must obtain the patient's consent for the proposed procedure before treatment is begun.''

It was understood that this matter would be brought back to the Executive Committee meeting if legal counsel foresees problems in its use.

Foreign Medical Graduate Committee — The Board of Directors created, in September 1981, a committee to gather information regarding Foreign Medical Graduates (FMGs) and to propose recommendations for possible MAG actions. The chairman of the committee, Joe C. Stubbs, M.D., reported its findings to the Board along with its recommendations. The Board of Directors approved the following recommendations to forward to the Composite State Board of Medical Examiners:

1) The MAG should urge the Composite State Board of Medical Examiners to require, as a prerequisite for an unrestricted license to practice medicine, graduation from a program of medical education leading to the medical degree that is accredited by the Liaison Committee on Medical Education, and that graduates of educational programs not accredited by the Liaison Committee on Medical Education be required to provide documentation of graduation from a school meeting equivalent standards and performances evaluation requirements. In this respect, we wholeheartedly endorse Resolution 56 and Recommendation 28, passed by the AMA House of Delegates in June 1982.

2) The MAG wholeheartedly endorses Recommendation 32, passed by the AMA House of Delegates in June, 1982, and thereby affirms that core clinical training should be provided by the parent medical school, and objects to the practice of U.S. institutions providing clinical experience for medical students of foreign schools.

3) The MAG should disseminate the following statement to the state medical community and to the public as a whole: ''The Medical Association of Georgia urges all American citizens who may be considering the pursuit of medical education in foreign medical schools to review critically and conscientiously the curriculum, facilities, faculty, and clinical training provided by the foreign medical school, insofar as graduation from that school may not lead to placement in a program of postgraduate medical education or the license to practice medicine in the United States. The prospective student should in fact be aware that some foreign medical schools may offer expensive educational programs which are so deficient in quality as to allow their graduates virtually no prospects for the future practice of medicine in this state or in the United States.''

4) The MAG should urge the Composite State Board of Medical Examiners to require that all graduates of foreign medical schools obtain three years of postgraduate medical training as a prerequisite for an unrestricted license to practice medicine. In this respect, the MAG endorses the action of the Texas Board of Medical Examiners and New York Board of Regents, which adopted this requirement in 1981.

AMA Delegate Report — Dr. Harrison L. (Jack) Rogers, Jr., of Atlanta, Speaker of the AMA House of Delegates, reported on the AMA Interim Meeting in Miami, Florida. He also announced that he would be a candidate for President-elect to the AMA in June, 1984. The Board unanimously commended Dr. Rogers for the fine work he is doing for organized medicine.

MAG Mutual Insurance Company — Dr. Charles D. Hollis, Jr., President of the MAG Mutual Insurance Company, presented Dr. James Sullivan, MAG Treasurer, a check in the amount of $65,269.78 as an installment on monies previously loaned by the MAG. Dr. Hollis reported that MAG Mutual had 1932 investors and 1140 applications received. MAG Mutual has organized an agency to insure those people who wish other types of insurance and already has a premium volume of $15,000. It was reported that as of February 1, 1983, there will be a rate increase of roughly 20% and this will come close to St. Paul's premium in 1982. Dr. Hollis personally thanked Dr. Hilt Hammett for his expertise and help in organizing MAG Mutual Insurance Company.

***Journal* Policy Statement Adopted** — The MAG Board of Directors adopted the following *JMAG* policy statement:

''MAG policy shall be to avoid publication of articles or editorials inferring the superiority of any given physician specialty group in the performance of diagnostic or therapeutic modalities over another physician specialty group. We concur with AMA policy (SR 88-A79 — CMS REP E I-82), that individual character, training, competence, experience, and judgment should be the criteria for judging the appropriateness of such performance.''

New Business — Dr. Raines announced that he will not seek re-election for Chairman of the Board in April.

Highlights — MAG Executive Committee Meeting — January 7, 1983

President's Report

Dr. Charles Hollis, Jr., welcomed Dr. James Glenn, Dean of Emory University School of Medicine, and Dr. Louis Sullivan, Dean of Morehouse School of Medicine, to this meeting. Dr. Hollis informed the Executive Committee that quarterly meetings were in progress between MAG and the Deans of Georgia's medical schools. These meetings are designed to better acquaint both parties with what is going on in their respective fields, and to create a closer working relationship between MAG and the medical schools.

Disciplinary Investigations

The Executive Committee was informed that current state law requires hospitals to inform the Composite State Board of Medical Examiners when disciplinary investigations are underway in a hospital concerning a medical staff member even when the staff member resigns prior to the completion of the investigation.

MAG Supports Hypertension/ Diabetes Appropriations

Executive Committee was urged to support continued funding of public health programs within the DHR. The Executive Committee reaffirmed MAG's previous policy support of the different programs within the Block Grant Project.

Report of the Secretary

Dr. William L. Amos, Jr., of Columbus, was appointed to serve on the Membership Insurance Committee, and Dr. Glenn L. Goodhart, of Atlanta, was appointed to serve on the Third Party Relations Committee. Both of these appointments take effect immediately.

Highlights — MAG Executive Committee Meeting Miami Beach — December 5, 1982

The Executive Committee met during the AMA Interim House of Delegates at Miami Beach on December 5, 1982. Here are some of its actions.

Under recently enacted federal law, it is no longer necessary for the Professional Review Organization function (formerly PSRO) to be administered by an organization separate from the state medical association. The Executive Committee therefore voted to contact the Georgia Medical Care Foundation to discuss the return of GMCF as an intergral unit of the MAG.

The Committee reviewed the success of the recent MAG Leadership Conference, and discussed plans for another such conference in the coming year.

The Executive Committee was informed that the state Department of Medical Assistance (DMA) has prepared a list of complicated ophthalmologic procedures for which optometrists will be reimbursed. The Committee voted to recommend that the Composite State Board of Medical Examiners obtain an opinion as to which licensed practitioners may legally pierce the skin. The Committee also instructed the MAG Third Party Relations Commitee to work with the DMA in arriving at an appropriate list of optometric procedures.

The Executive Committee made several nominations. Dr. Joe Bailey, of Augusta, was recommended for the Tenth District seat on the Composite State Board of Medical Examiners. Dr. Charles C. Stamey of Columbus was nominated as a member of the AMA Steering Committee for its Hospital Medical Staff Section.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from October through December, 1982.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Charles P. Adams, Atlanta
Oscar E. Aguero, Valdosta
Vicente R. Ajoy, Jonesboro
Stanley P. Aldridge, Decatur
Manuel Alexander, Commerce
Susan Alexander, Commerce
Robert W. Amler, Atlanta*
Blanca R. Anton, Decatur
David F. Apple, Atlanta
Catalina T. Aranas, Columbus
Howard E. Ayliffe, Macon
J. Donald Bartley, Columbus*
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James H. Beall, Athens
Douglas Ronald Bess, Atlanta*
Ashok Bhoomkar, Atlanta*
John F. Bigger, Augusta
Emmett R. Bishop, Savannah*
Clorinda S. Bohler, Augusta
John P. Boineau, Augusta*
Alan Paul Brown, Savannah
William H. Buntin, Albany
John F. Butterworth, Savannah*
William P. Byars, Augusta
Glyn G. Caldwell, Atlanta*
Gordon C. Carson, Savannah*
Harrison D. Cavanagh, Atlanta
Rajinder Chhokar, Columbus*
Sun Ik. Choi, LaGrange
Cyrus Michael Cioffi, Atlanta
Newton T. Clark, Atlanta
William C. Collins, Atlanta
Eugene L. Crews, Marietta
George Lee Cross, Atlanta
John V. Cuff, Athens
John R. Curtis, Athens
William G. Cutts, Canton
Curtis Le Voyd Davis, Atlanta*
J. William DeHaven, Savannah
Edward F. Dowing, Savannah
Maxwell Armand Eidex, Decatur
Howard S. Ellison, Conyers*
William Elsner, Columbus
Gerson Z. Escondo, Midland*
William L. Eubanks, Atlanta
John S. Evans, Atlanta
Robert F. Finegan, East Point
Edmund M. Fitzgerald, Dublin
Darius Flinchum, Atlanta
Virginia D. Floyd, Decatur*
Mark F. Friedman, Atlanta*
Richard J. Friedman, Marietta*
David J. Frolich, Macon
Tama Y. Fuller, Atlanta*
Henry Gall, Cairo
Carmen Gannon, Savannah
Stewart D. Gilbert, Tifton
Jonathan C. Glen, Savannah*
James T. Goodrich, Atlanta*
Samuel M. Goodrich, Milledgeville
James W. Gordon, Atlanta
Ralph P. Grant, Atlanta
Charles G. Green, Jr., Augusta
Charles Gray Green, Waynesboro
Magdi B. Hanna, Columbus
James R. Hattaway, Albany
Darvin L. Hege, Atlanta
Edgar R. Hensley, Augusta
John T. Holloway, Waycross
Wilmer O. Holloway, Tifton
Robert W. Horseman, Evans
William C. Humphries, St. Simons Island
James B. Hurst, Milledgeville
Charles W. Johns, Macon
Gustaf H. Johnson, Savannah
Mila Jorda-Montesclaros, Columbus*
Alfred Joseph, Atlanta
Henry Jerrold Kaplan, Atlanta
Sahin Kocacitak, Ft. Oglethorpe
Alex Z. Klopman, Roswell
Charles C. Lamb, Albany
Stephen John Lange, Jr., Savannah
Sidney R. Lee, Atlanta
Ian I. Lipsitch, Atlanta
Grady E. Longino, Dublin
Earl A. Loomis, Augusta*
Louis O. J. Manganiello, Augusta
John Owen Martin, Macon
Miles H. Mason, Duluth
Mohammad A. Masroor, Savannah
Fayette M. McElhannon, Athens
P. Robert Mitchell, Marietta
Herman G. Morgan, Valdosta*
Philip E. Morgan, Norcross
John J. Morley, Savannah*
J. V. Morrison, Savannah
William J. Morton, Atlanta
Richard N. Moss, Augusta
Paul S. Mote, Augusta
Michael L. Nash, Savannah
Benjamin B. Okel, Decatur
Carlos Ordonez, Dunwoody
Harry Parks, Atlanta*
Alan S. Peiken, Columbus
James M. Petway, Augusta
William C. Pfister, Tifton
Muhammed Shahidur Rahman, Fort Benning*
Frank A. Raila, Dublin
Lawrence A. Rathbun, Savannah
Sudhakara M. Reddy, Statesboro
James P. Reitt, Atlanta
Seaborn A. Roddenbery, Columbus
Harry E. Rollings, Savannah
Julius T. Rucker, Augusta
Richard Allen Sanders, Columbus
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* Non-members as of 1/6/83 when this was typed.

Classifieds

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The U.S. Department of Labor, Office of Workers' Compensation Programs seeks qualified medical specialists to serve as Medical Advisors and to review workers' compensation case files within their specialties. Qualifications: Board-Certified, eligible physicians only. Description: Work involves reviewing case files containing claims for benefits under the Federal Employees' Compensation act, and offering medical opinions in those files. The physician schedules his own hours and workplace. Fee negotiable. For further information call: Mr. Francis Hammond or Mrs. Manuella Hill, (404) 881-7812 or 7814, from 8:30 am to 5:00 pm, Monday through Friday.

Surgeon — For hospital serving 20,000 population near Atlanta. Beautiful location. Competitive salary guarantee, with fringes and incentives. Send CV to Gail Leo, Healthcare Management Group, Two Riverchase Office Plaza, Ste. 100, Birmingham, AL 35244, or call (205) 988-4488.

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Instruments and equipment of retired ophthalmologist. Includes Green's refractor, slit lamp, B & L hydraulic chair, mechanical stand. Operative and office small instruments. All or parts. H. R. Perkins, M.D., 1118 Milledge Rd., Augusta, GA 30904.

New, totally equipped and furnished office building suitable for 1 or 2 family practice physicians or internists, available immediately. Doctor retiring. Located in university town approximately 60 miles from Atlanta, GA. Reply to Box 3-A, c/o Journal.

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Medical Technologist Wanted to perform chemical, microscopic, serologic, hematologic, immuno-hematologic, parasitic, and bacteriologic tests to provide data for use in treatment and diagnosis of disease. Receives specimens for laboratory, obtains such body materials as urine, blood, pus, and tissue directly from patient, and makes quantitative and qualitative chemical analyses. Cultivates, isolates, and identifies pathogenic bacteria, parasites, and other micro-organisms. Cuts, strains, and mounts tissue sections for study by pathologist. Groups or types blood and cross matches that of donor and recipient to ascertain compatibility. May take electrocardiograms. Require MS degree Medical Technology or equivalent plus 2 years experience or 2 years related experience in medicine. Salary $320 per week for 40 hour week. Qualified applicants contact Georgia Employment Service, One Peachtree St., NE, Atlanta, Control #73818.

Medical Technologist Wanted to perform chemical, microscopic, serologic, hematologic, immuno-hematologic, parasitic, and bacteriologic tests to provide data for use in treatment and diagnosis of disease. Receives specimens for laboratory, obtains such body materials as urine, blood, pus, and tissue directly from patient, and makes quantitative and qualitative chemical analyses. Cultivates, isolates, and identifies pathogenic bacteria, parasites, and other micro-organisms. Cuts, strains, and mounts tissue sections for study by pathologist. Groups or types blood and cross matches that of donor and recipient to ascertain compatibility. May take electrocardiograms. Require MS degree Medical Technology or equivalent plus 2 years experience or 2 years related experience in medicine. Salary $320 per week for 40 hour week. Qualified applicants contact Georgia Employment Service, One Peachtree St., NE, Atlanta, Control #73814.

SERVICES

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Pinworms work the night shift



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Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

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Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

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References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. **2.** Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. **3.** Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.

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First Medical History of Georgia to be Published

The State of Georgia is celebrating its semiquincentenary in this year of 1983. Since there was one medical practitioner on board the *Anne* which brought the first shipload of colonists to Yamacraw Bluff in 1733, the medical profession in Georgia also is celebrating its 250th birthday.

Do you know who that first surgeon was, who also became the first casualty of the new enterprise, and why his name has been obscured by others over the years?

Do you know the stories and names behind the first autopsy, the first case of child abuse, the first organized medical society, the first medical school, the first person to receive an M.D. degree in Georgia, and the first woman to receive that distinction?

Are you aware of the year-to-year struggles that faced the profession after the first man set foot on Georgia soil?

These and many other questions will be answered for you in the upcoming book entitled, *The Medical Profession in Georgia, 1733-1983*, which is being written by Mrs. Brit B. (Evelyn Ward) Gay, Jr., a member of the Auxiliary to MAG.

Proceeds from this 400-page hardcover volume will go to support the William R. Dancy M.D. Student Loan Fund, a project of the state auxiliary, which furnishes monetary aid to medical students in Georgia's medical schools.

The book, to be printed by The Ovid Bell Press, Inc., of Fulton, Missouri, which prints the *Journal of the Medical Association of Georgia*, will be ready for distribution by November 1, 1983, just in time to make an excellent gift for a family member, a friend, a favorite school, your neighborhood library, or as a special gift for yourself.

Medical society and auxiliary members who place orders before July 1, 1983, will pay only $20.00 per copy. After that date, copies will be $25.00.

The first edition is limited, so use the following blank to get your order in now for one or more copies to assure that your name will be on the mailing list in November.

Check in the amount of $_____ for _____ copy(ies) of *The Medical Profession in Georgia, 1733-1983* is enclosed. I understand that the books will be mailed to me by November 1, 1983. (Make check payable to the Auxiliary to MAG, and mail to Mrs. Brit Gay, 911 Vistavia Circle, Decatur, Ga. 30033.)

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Address

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

Photograph of Mount McKinley in Alaska was taken by Charles W. McDowell, Jr., M.D. Read about his climbing adventure on page 257.

Artwork by Richard Lyons, of Richard Heiman Advertising, Inc., Atlanta.

Incidental Intelligence . . .

Rules of Georgia Department of Human Resources, Physical Health — Prophylactic Treatment of the Eyes of the Newborn

290-5-20-.01 Purpose. Amended. To prescribe the prophylactic treatment of the eyes of the newborn; to require the person in attendance at childbirth to instill the prophylactic in the eyes of the live newborn immediately following birth; and to require the reporting of Ophthalmia Neonatorium.

290-5-20-.02 Definitions. Amended. Unless a different meaning is required by the context, the following terms as used in these Rules shall have the meaning hereafter respectively ascribed to same:

(1) "Ophthalmia Neonatorium" means an infection by *Neisseria gonococcus* of the eyes of an infant and occurring in the early neonatal period.
(2) "Prophylactic treatment" means the instillation of a one (1) percent aqueous silver nitrate solution in a single dose ampule, or an ophthalmic ointment or drops containing one (1) percent tetracycline or one-half (0.5) percent erythromycin in a single-use tube or ampule in the eyes of the live newborn immediately following birth. None of the agents used for prophylaxis should be flushed from the eyes following instillation.

290-5-20-.03 Provisions. Amended.

(1) The person in attendance at any childbirth shall instill the prophylactic treatment in the eyes of the live newborn immediately following birth.
(2) On written application setting forth the objectives, the reasons requiring the use of a prophylactic treatment other than that defined in Section 290-5-20.02 (2) and the control methods to be followed, the Georgia Department of Human Resources may authorize the use of another agent or method of prophylactic treatment of the eyes of the newborn for research and other controlled use.
(3) Any physician licensed to practice in Georgia under the Medical Practice Act (Ga. L. 1913, p. 101; 1918 p. 173; 1939, p. 226; 1963, p. 285) shall report each case of Gonococcal Ophthalmia Neonatorium, diagnosed or treated by him.
(4) Each person who by Georgia law is permitted to attend the pregnant woman at childbirth but who is not permitted by Georgia law to prescribe medication or treat Ophthalmia Neonatorium shall immediately upon discovery report to the District Director of Public Health or the County Public Health Nurse, any newborn with signs of Ophthalmia Neonatorium such as swelling, redness of eyes or any discharge therefrom.

Burn Treatment Program — Children's Medical Services, Georgia

Effective January, 1983, children who sustain burns and who are financially eligible for Georgia Department of Human Resources, Children's Medical Services (formerly Crippled Children's Program) will be treated at Eugene Talmadge Memorial Hospital in Augusta or at Grady Memorial Hospital in Atlanta. Because of limitation in funds, hospital bills incurred at any other facility will not be paid by Children's Medical Services.

The Grady and Talmadge programs will offer comprehensive care for all eligible children referred for acute burn care and long-term management.

The team in Atlanta will be headed by Dr. Maurice J. Jurkiewicz. Emergency burn referrals should be directed to the admitting physician for the Grady Burn Unit (404) 588-4307. For direct communication with Dr. Jurkiewicz, call (404) 892-4411.

The team in Augusta is headed by Dr. Robert A. Parrish for children ages birth through 12 years and by Dr. Richard C. Treat for children 13 through 20 years. Emergency referrals for children 12 years and younger should be directed to Mrs. Pat Bentley (404) 823-3016. If unable to contact Mrs. Bentley, call Dr. Parrish (404) 828-3941. For children 13 years through 20 years, contact Dr. Treat (404) 828-3153.

Utilizing a team approach, Children's Medical Services provides a variety of diagnostic and treatment programs for financially and medically eligible children up to age 21 years. Further information on the diagnostic conditions eligible for care and the financial eligibility criteria is available through local health departments or by calling the State Child Health Program at (404) 656-4833.

Due to budgetary limitations, individual notices of this information will not be mailed to individual physicians, so it is suggested this article be clipped and filed for future reference.

AMA Opposed to Diagnosis-Related Medicare Payments

The AMA has testified against the Reagan Administration's proposal to base Medicare payments to hospitals on the patient's diagnosis.

Appearing before the House Ways and Means Subcommittee on Health, Jerald Schenken, M.D., a pathologist from Omaha, Neb., and Vice Chairman of the AMA's Council on Legislation, recommended that the committee "reject the Administration's proposal to impose an untried system across the nation."

He called instead for more prospective payment dem-

onstration projects and further analysis of the demonstration projects already in place.

The AMA opposes "a radical change in the Medicare hospital reimbursement system without assurances that quality of care will be maintained," he explained.

Dr. Schenken said the proposal, which would set a price for each of 467 diagnosis-related groups (DRG's) and which the Administration wants to implement nationwide Oct. 1, "has never been tried, even on a limited scale."

The DRG experiment in New Jersey, which began three years ago, differs significantly from the Administration proposal, and in any event, the New Jersey experiment has not been evaluated yet, he said.

The Administration's proposal, which has not been submitted to Congress as legislation, aims to control the spiraling costs of Medicare, which now devotes 68% of its $60-billion budget to hospitals.

Proponents of the plan say that if hospitals were paid per DRG, they would have an incentive to be efficient. Hospitals now are reimbursed by Medicare on the basis of their costs.

The DRG system divides illness into 467 categories by primary and secondary diagnoses, the primary procedure used (if there is surgery), the age of the patient and the patient's discharge status. DRG 167, for example, is an appendectomy without complicated principal diagnosis, complications, or associated illness for a patient under 70.

The American Hospital Association also has proposed a DRG-based prospective payment system for Medicare, although it differs from the Administration's proposal on several points, particularly as to how prices for each DRG should be determined.

Dr. Schenken said the AMA "has some of the same concerns about the AHA proposal as it has about the Administration's." He added, however, that he saw merit in experimenting with the proposal, presumably on a trial basis on a state or local level.

The AMA supports experimentation with prospective payment systems that create incentives for hospitals to be more cost conscious, Dr. Schenken testified. He called upon the committee to authorize that the Administration's proposal "and other prospective pricing proposals" be demonstrated on a limited scale in various states before being considered for national implementation.

"Continued demonstration projects and thorough analysis can lead to the development of a responsible and effective prospective pricing methodology," he said. "While this may not immediately reach the desired cost savings, it will not place Medicare beneficiaries at risk of facing a loss of quality medical care."

Dr. Schenken said that if a hospital were underfunded by Medicare, it would respond by shifting costs to other payers, deferring such costs as maintenance, reducing nursing and other essential patient care staff, and postponing or eliminating necessary modernization and technological improvements, thus depriving patients of the highest quality of care.

"In extreme cases hospitals providing essential care could be forced to close," he said.

He added that the AMA was concerned that the Administration's proposal could foster a two-tiered system of health care, with one level of care for private-pay patients and one for Medicare patients.

The Administration's proposal differs from the New Jersey system on several important points. The New Jersey system applies to all payers — private insurers, Medicaid, and Blue Cross. The Administration's proposal would apply only to Medicare. Also, New Jersey has no hospitals under 100 beds. The Administration's proposal would apply to all hospitals, except hospitals that are sole providers of care in a community.

The National Kidney Foundation Releases Results of the First National Survey on Public's Attitude on Organ Donation

If Americans willing to donate their kidneys or those of their loved ones upon death did so, there would be no shortage of kidneys available for transplantation, the National Kidney Foundation reported today.

According to a survey conducted by the Gallup Organization for the Foundation, when asked if they would "give permission for donation of a loved one's kidneys," 83% said they were likely to do so.

Of the 40% willing to give permission to donate their own organs, less than half (41%) have told their family members about their desire and even fewer (31%) have signed an organ donor card, the survey revealed.

"The results of the survey are very positive and dramatically point out how successful the Foundation has been in educating the public about organ donation and transplantation," Ira Greifer, M.D., NKF medical director, commented. "If all those individuals who wanted to leave their kidneys or other organs to people in need told their families about it, there would be a doubling or tripling of available organs. The organs donated would be acquired more quickly which would dramatically change the success of kidney and other organ transplants."

There are presently 4,800 kidney transplants performed each year but approximately 10,000 medical eligible patients do not receive one because of a lack of suitable donors, Dr. Griefer said.

"We now know what the Foundation's major public education effort must be in the future," Dr. Griefer said. "We must make every effort to get individuals to talk to their families, to get distinguished Americans to make known publicly their desire to donate their organs. The reluctance of the physician to ask must be overcome."

The survey was commissioned by the Foundation as a part of a nationwide week-long campaign (Feb. 28-March 4) to educate Americans about the importance of organ donation and transplantation.

The Gallup Survey was conducted by in-person interviews among a nationally representative sample of 1,574 persons age 18 or over. The results reported here are from those who answered yes to the question, "After people die, it is often possible to remove one or more of their vital organs, such as eyes, kidneys, hearts, or livers and transplant them into another person whose eyes or kidneys are failing. Have you heard or read anything about organ transplants?" A total of 93% responded yes. Interviewing was conducted from January 14 through January 22, 1983. The margin of error is a plus or minus 3%.

Not surprising, those who are more likely to want their

kidneys donated after death are more educated and with higher incomes than those opposed or unwilling to donate.

Blacks are less likely than whites to donate their kidneys despite the fact that the incidence of kidney disease is much higher in blacks than whites — 200-250 million in blacks/100 per million, black included, in the overall population.

"I think the reluctance of blacks to donate is due more to their distrust of the system than to lack of compassion," Dr. Griefer observed. "Many feel the system does not work for them. It's the Foundation's job to alleviate these fears and explain that kidneys are transplanted on a first come, first serve basis."

Of those respondents who say they have never thought about donating their organs, 20% said, "I never really thought about it," and the same proportion (20%) cited as "very important," the reason "I don't like the idea of somebody cutting me up after I die."

Only 7% of the respondents cited religion as a very important reason for not wanting their kidneys donated after death.

A complete copy of this survey is available upon request.

The National Kidney Foundation of Georgia is the major voluntary health care agency dedicated to the prevention, treatment, and cure of kidney disease. Currently in Georgia, over a quarter of a million men, women, and children are suffering from one of the many diseases of the kidney. Over 2,000 have lost the use of both of their kidneys and must depend on a form of dialysis to live. Over 400 are waiting for a kidney transplant. "Unfortunately, their wait could be a long one," Dick Reader, Executive Director of the Foundation, reports. "In Georgia, we have a shortage of donors. That's why it is so important that every Georgian sign the organ donor card on the back of his/her next driver's license."

Budget Considerations

The total budget unveiled by President Reagan earlier in the month calls for $848.5 billion in government spending for fiscal year 1984.

Of that total, the U.S. Dept. of Health and Human Services accounted for $288.8 billion, the third largest budget in the world, after the United States and Soviet Union, according to a statement by department officials.

The overwhelming proportion of the HHS budget is slotted for the Social Security Administration at $194.7 billion. Budgets of specific interest to medicine are the Public Service funds targeted at $7.9 billion, and the Health Care Financing Administration budget of $80.7 billion.

Included in the HCFA budget are dramatic proposals to change the Medicare program. Among them:

- A prospective payment system for hospitals.
- Restructured coinsurance for hospitalized Medicare recipients.
- A voluntary voucher program that would allow Medicare recipients to enroll in prepaid health plans, such as health maintenance organizations (HMOs).
- A freeze on physician fees for one year, with no rules about assignment, meaning that physicians can accept Medicare reimbursements as payments in part and bill patients for the remainder.
- An increased premium charge for Part B coverage of physician fees, including an index for the deductible.

Other initiatives include a co-payment plan for Medicaid recipients calling for $1 per outpatient visit and $1 per hospital day for beneficiaries on welfare ($1.50 and $2 for beneficiaries not on welfare.)

The budget also includes a proposal to limit the tax-free amount an employer can contribute to health benefits. The line would be drawn at $175 per month for family coverage and $70 per month for individual coverage.

If the proposals are accepted, they will hold the annual growth rate of the HHS budget to 5%, down from a high of 17% in fiscal year 1981.

Competitive-Model Plan For Health Care

The long-awaited consumer choice, or competitive-model plan for health care, appears to have been shelved by the Reagan Administration. Instead of a comprehensive plan that would interconnect public and private payment systems for medical care, the Administration has offered a piecemeal approach that incorporates some of the competitive ideas, such as the voucher program and the tax limit on employer benefits contributions.

Medicare Co-Payment Provisions

The most startling proposal relates to the co-payment provisions for Medicare recipients, both in the hospital plan and in the physician plan. Observers long have thought that government would not propose changes in the benefits packages, but these proposals look very much like such changes.

The Medicare catastrophic coverage proposal is billed in the budget as a provision of "unlimited hospital coverage of catastrophic illness for the first time."

Explaining the provision, HHS officials pointed out that "under current law the beneficiary hospitalized in 1984 for 150 consecutive days would owe $13,475 from his or her own pocket.

"The beneficiary would also bear the full cost of all subsequent hospital days," they added.

"Under the new plan, the beneficiary's expenses would be $1,530, with no co-insurance after 60 days."

While the coverage looks greater, the fact is that the government expects to save $663 million in fiscal 1984 by implementing the plan.

What it in effect will do is shift co-payment to the area of greater activity for Medicare hospitalization. Under the plan now in effect, recipients pay the full cost of hospitalization on the first day, but from the second to the 60th day there is no cost sharing. From the 61st to 90th day, the recipient share now would be $87.50 per day, and $175 per day from the 91st to the 150th day.

The new plan calls for the same full pay for the first day of hospitalization; about $28 per day from the second to the 15th days; about $17.50 per day from the 16th to 60th day; and catastrophic (no pay) coverage after the 60th day.

Explaining the budgetary savings, Robert J. Rubin, M.D. HHS Assistant Secretary for planning and evalua-

tion, pointed out that the average hospital stay for a Medicare recipient is 11.5 days. This will add $280 from each recipient to the program, resulting in the projected savings, he said.

He added that only 200,000 of Medicare recipients, numbering some 29 million, ever stay more than 60 days during a given period.

Additional savings will be realized by the prospective payment of hospitals based on 467 diagnosis-related groups (DRGs). This builds on the Medicare case management plan "associated with hospital reimbursement changes enacted in the Tax Equity and Fiscal Responsibility Act," officials said.

The projected freeze on physicians' reimbursement under Medicare is expected to save $700 million, officials said. Dr. Rubin said that about half of the physicians in the country accepted assignment (Medicare reimbursements as payment in full). He added that there was nothing in the proposed rules to inhibit physicians from passing on fee increases to patients.

The budget proposals also anticipate gradual change in the premium and deductible for optional Medicare physician coverage under Part B of the program.

"When Medicare was established the premium was intended to cover 50 percent of Part B costs, but premiums now cover less than 25 percent of costs," officials said.

That percentage would move back up to 35 percent by 1988 if the new proposals are accepted, Dr. Rubin said. The per-month premium of $12.20 will remain in effect until the end of the year.

In addition, the deductible will be indexed to keep pace with costs. That savings will amount to $46 million in fiscal 1984. The premium proposals will result in $359 million additional costs for fiscal 1984, but earn $575 million in savings for the following fiscal year.

The increases in hospital co-payments, premium payments, and the prospect of additional billings from physicians who do not accept assignment probably will make enrollment in HMOs more attractive for Medicare recipients, Dr. Rubin said.

The new budget proposes to sweeten that possibility by increasing what the government will pay to "an amount equal to 95 percent of per-person costs of the Medicare program." Dr. Rubin pointed out that the government now pays only 80 percent.

"Medicare would remain the basic national health plan for the elderly, and alternative plans would have to provide coverage at least equal to Medicare's" officials said.

"The voucher plan in essence invites private providers and insurers to 'outbid' Medicare if they can. The voucher program would be entirely voluntary, and beneficiaries could re-enter the Medicare system.

"In the case of low-priced alternative plans, cash rebates could be made to the beneficiaries."

The cap on tax-free health benefits would result in an addition of $2.3 billion in income tax revenues in fiscal 1984, but that gain in revenue was not the main thrust of the proposal.

"The point here is that government will no longer subsidize medical care in that way," Dr. Rubin said.

The initial impact may be limited, since the average monthly health benefit is $125, well below the proposed $175 per month cutoff for family coverage.

"Currently, about 30 percent of those with employment-based health coverage receive employer contributions above these limits," officials said.

"While individuals and companies would remain free to purchase as much health coverage as they desire, the new provision would eliminate the bias that now works in favor of high-priced coverage and against comparable higher wages," they added.

In addition to the Medicaid co-payments proposals, which would add an estimated $249 million in savings, the budget proposes maintaining reductions in the federal share of Medicaid.

"The plan would extend beyond fiscal 1984 the reduction in federal payments to states passed in the Omnibus Budget Reconciliation Act of 1981," officials said.

"The reduction would be cut, however, from 4.5 percent to 3 percent. The reduction will remain in place for an indefinite period, leaving in place the incentive for states to continue seeking new cost-saving Medicaid policies."

Officials said they expected to save $524.9 million in fiscal 1985 by extending the reduction, adding that there would be no effect felt during 1984.

Budget Cuts

Other HCFA cuts include a closing down of the professional standards review organizations regulatory effort. In the past 3 years, funding has gone from $96 million to $50 million to zero proposed for fiscal 1984. Also shut down was the end-stage renal disease councils program previously budgeted at $5 million.

Proposed budgeting for the National Institutes of Health was increased by $73 million to $4,077 billion in fiscal 1984, and budgets for the Alcohol, Drug Abuse, and Mental Health Administration was increased by a modest $1 million to $421 million.

In for severe paring was the Health Resources and Services Administration, whose budget was cut from $1.207 billion in fiscal 1983 to $977 million in 1984.

Totally eliminated from that budget was the health planning program, previously budgeted at $58 million, and drastically cut by $56 million was the health professions education program, now budgeted at $116 million.

Also cut within the Health Resources and Services Administration was the Indian Health Service, down $7 million from $660 million in fiscal 1983 to $653 million in fiscal 1984.

Funding for the National Health Service Corps would continue at $96 million, providing for a field strength of 3,283 physicians and other health personnel.

The Food and Drug Administration budget would be increased $19 million to $386 million for fiscal 1984; and the Centers for Disease Control would increase to $270 million from $249 million in fiscal 1983.

Block grants for health services in prevention; alcohol, drug abuse, and mental health; primary care; and maternal and child health would be maintained at the same budget level of $1,357 billion for fiscal 1984.

MEDICAL MEETING CALENDAR

APRIL

24 — *Atlanta:* **Postgraduate Course — Pancreas, Liver, and Biliary Tract.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

25-27 — *Atlanta:* **American Association for Thoracic Surgery.** Contact AATS, 13 Elm St., Manchester, MA 01944. PH:617/927-8330.

25-27 — *Atlanta:* **Scientific Program of the Southeastern Surgical Congress.** Category 1 credit. Contact Southeastern Surgical Congress, 315 Blvd., NE, Ste. 500, Atlanta 30312. PH:404/681-3636.

MAY

2-7 — *Augusta:* **Eighteenth Annual Family Practice Symposium.** Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

5-8 — *Sea Island:* **Georgia Society of Ophthalmology Annual Meeting.** Category 1 credit. Contact Talitha Russell, Exec. Secy., GSO. 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

5-8 — *Savannah:* **The Patient with Pulmonary Disease Presenting for Anesthesia and Surgery.** Category 1 credit. Contact Nancy Cunningham, Am. Acad. of Anesthesia Assocs., P.O. Box 77253, Atlanta 30357.

6-8 — *Atlanta:* **Arrhythmias and Cardiac Ischemia: Diagnosis and Management.** Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., Div. of Postgraduate Ed., 64 Inverness Dr., East, Englewood, CO 80112. PH:800/525-8651.

7 — *Atlanta:* **Infectious Diseases in the 80s.** Category 1 credit. Contact Stephen Daniel, Morehouse Sch. of Med., 830 Westview Dr., Atlanta 30310. PH:404/752-1305.

9-12 — *Atlanta:* **American College of Obstetricians and Gynecologists.** Contact ACOG, 600 Maryland Ave., SW, Ste. 300 East, Washington, D.C. 20024. PH:202/638-5577.

9-12 — *Atlanta:* **Cardiology.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

12-14 — *Atlanta:* **Pathology Update.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

13 — *Atlanta:* **Cerebrovascular Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

13-14 — *Atlanta:* **Update of Diagnosis and Treatment of Lupus Erythematosus.** Category 1 credit. Contact Edwin S. Ehrenhalt, Lupus Treatment Ctr., West Paces Ferry Hosp., 3200 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-0351, x844.

18-22 — *Atlanta:* **Family Medicine Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-20 — *Columbus:* **Eleventh Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Ctr., P.O. Box 951, Columbus 31994. PH:404/324-4711.

27 — *Sea Island:* **Annual Meeting, Georgia Neurosurgical Society.** Contact Fremont P. Wirth, MD, 4 Jackson Blvd., Savannah 31405. PH:912/355-1010.

JUNE

6-8 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, RN, Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

9-12 — *Sea Island:* **Annual Meeting of the Georgia Society of Dermatologists.** Category 1 credit. Contact Robert M. Kelleher, M.D., 6500 Vernon Woods Dr., NE, Ste. D-8, Atlanta 30328. PH:404/256-9400.

13-17 — *Lake Arrowhead:* **Orthopaedics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-23 — *Atlanta:* **2nd International Symposium on Legionella.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Orlando, FL:* **Arthoscopy Need Not Be Frustrating (Operative Arthroscopy).** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-2967.

JULY

11-12 — *Atlanta:* **MKSAP VI — Part III — ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Kiawah Island, SC:* **Clinical Obstetrics.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21 — *Hilton Head, SC:* **Clinical Cardiology.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG. Augusta 30912. PH:404/828-3967.

22-23 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

25-27 — *Kiawah Island, SC:* **Pediatric Update 1983.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

28-31 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

OFTEN INSEPARABLE: PAIN AND ANXIETY

A pathologic partnership one sees every day

Pain—triggering anxiety—which accentuates the perception of pain...together they're worse than either alone. And since they're usually both present in musculoskeletal disorders, the best therapy is often a combination of analgesic and anxiolytic agents. Equagesic ® -M combines the pain relief of aspirin with the tension-reducing properties of meprobamate—because together they're better than either alone.

See important information on next page.

Wyeth Laboratories
Philadelphia, Pa. 19101

tablets

Equagesic®-M

(meprobamate with aspirin) ℗ Wyeth

Effective analgesic/anxiolytic alliance





Prompt, effective relief from the dual burden of pain and anxiety

tablets

Equagesic®-M

(meprobamate with aspirin) © Wyeth

Effective analgesic/anxiolytic alliance

Proven superior to aspirin alone in controlled clinical trials

(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred.

Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12-to-48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical cord blood at or near maternal plasma levels and in breast milk at lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic®-M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN. May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS:

0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

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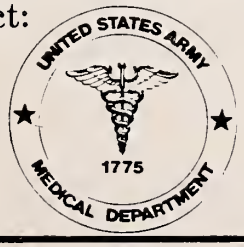
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Selected Abstracts from Scientific Sessions of the American Heart Association, Georgia Affiliate, October, 1982

Hemodynamic Characteristics of Current Prosthetic Heart Valves.

Ajit P. Yoganathan, Robert H. Franch, Georgia Tech, Atlanta.

The pressure gradient and regurgitation characteristics of a prosthetic heart valve design are two of the major determinants in its clinical use. It is therefore very valuable to the physician to have such information available to him from standardized *in vitro* testing procedures. *In vitro* pressure gradients and regurgitation volumes (RV) have been measured across different designs of aortic and mitral valve prostheses in a pulse duplicator system. The following valve designs were studied: Starr-Edwards (SE), Smeloff-Cutter (SC), Bjork-Shiley (BS), Hall-Kaster (HK), Omni-Science (OS), St. Jude (SJ), Carpentier-Edwards (CE), Ionescu-Shiley (IS), and Hancock (H). From the pressure gradient measurements, the effective orifice areas (EOA) and performance indices (PI) were calculated for the various valves. The two ball valve designs and the porcine valves had the lowest PI (0.3 to 0.4), while the BS and IS valves had PIs in the range of 0.4 to 0.5. The newer designs of mechanical valves (SJ, HK, OS) had the largest PI (0.6 to 0.7), indicating the lowest resistance to blood flow. RV of 7 to 15 ml/stroke were measured for all the mechanical valves except the SE valves. The SE valves had RV of 4.0 to 5.5 ml/stroke, while the tissue valves had little or no leakage volumes. Therefore, the newer mechanical valves have lower gradients but larger RV. On the other hand, current tissue valves are more stenotic but have very low RV.

Clinical Pathologic Problems Observed With Prosthetic Heart Valves: Possible Relationship to Fluid Dynamics.

Ajit P. Yoganathan, Robert H. Franch, Earl C. Harrison, Georgia Tech, Atlanta.

Some of our clinical and pathologic observations and *in vitro* fluid dynamic experiences with the Bjork-Shiley (B-S), Starr-Edwards, Smeloff-Cutter, Kay-Shiley, and tissue valves are discussed. Using laser-Doppler anemometry, it has been possible to quantitate *in vitro* the flow fields in the immediate vicinity of valve prostheses. These measurements appear to predict potential clinical problems with different valve designs. For example, in our clinical use of the B-S valve, we have observed thrombus formation and tissue overgrowth on recovered valves. Varying degrees of the thrombus formation were observed in the minor outflow region, including the depression in the outflow face of the disc and the metal strut bridging this area. Tissue overgrowth was noted along the perimeter of the prosthesis adjacent to the minor outflow region. *In vitro* measurements identified a zone of stagnation near the outflow face of the disc of the B-S valve. The average velocities in the major and minor outflow regions were found 100 and 25 cm/s, respectively, and the corresponding peak shear stresses were approximately 70 to 15 N/m^2. There is reason, then, to attribute the thrombus formation and tissue overgrowth to the stagnation zone and the low shear in the minor outflow region. Correlative studies as described above are very useful in identifying potential clinical problems with different valve designs.

Ergonovine-Induced Esophageal Spasm in Patients Catheterized for Chest Pain.

W. Story, P. Murphy, C. Quinn, J. Hoopes, E. Manolas, M. Caruso, J. Hollman, R. H. Franch, J. S. Douglas, S. B. King, Emory Univ. School of Medicine, Atlanta.

We attempted to determine the incidence of diffuse esophageal spasm in patients with chest pain suggestive of angina whose cardiac catheterization fails to reveal an etiology for symptoms in obstructive coronary disease or coronary artery spasm.

A total of 118 patients with insignificant coronary atherosclerosis were given a barium swallow in the supine position with fluoroscopic analysis of esophageal motility at the time of cath. Then ergonovine maleate was administered by peripheral IV in incremental doses of 0.05, 0.1, and 0.2 mg for a total dose of 0.35 mg with continuous monitoring of BP, ECG, and symptoms. Repeat injections of the coronaries were done to evaluate for coronary spasm. If negative, a repeat barium swallow was done, and read blindly by a GI radiologist. A total of 110 barium swallows were suitable for interpretation, and of these, 23 exhibited diffuse esophageal spasm. All but 4 of these patients experienced chest pain, often stated to be identical to their previous symptomatology. Of the 23 positive barium swallows, 4 patients had spontaneous esophageal spasm, but the remaining 19 positives would have been missed without ergonovine provocation.

We conclude that ergonovine provocation of diffuse esophageal spasm is a clinically useful method of pursuing the etiology of chest pain symptomatology.

Telephonically Home Monitored Exercise Following Coronary By-Pass Surgery.

T. Chiaramida, M. LeMay, B. Johnston, G. Fletcher, Emory University, Atlanta.

To assess effectiveness, safety, and technical feasibility (ESTF) of telephonically home monitored exercise (THME), 38 patients (pts) 6-10 days after coronary surgery (CS) were prospectively randomized into a 12 week (12 wk) activity protocol (P). ECG and blood pressure (BP) were monitored before and immediately after exercise (E). E treadmill and oxygen consumption (VO_2) studies were done initially (I) and at 12 wks (F). To date, 4 control (C) (Walk P) and 5 experimental (Ex) (Bicycle P) pts have completed 12 wks. Results (mean values) are:

	VO_2 (ml/kg/min)			VE (l/min)		
	I	ti	F	I	ti	F
Ex (N = 5)	13.3	16.6	23.9	34.6	32.4	53.5
C (N = 4)	12.9	13.1	23.7	28.8	19.9	41.8

	Rate/Systolic Pressure Product		Treadmill Time (TT)	
Ex	16,576	23,694	9.5	19.3
C	16,416	21,307	9.4	21.3

ti = data collected at F evaluation at the time equal to the end point of the I evaluation; VE = ventilation

There were no interruptions of E for arrhythmias and no abnormal BP responses. Technically clear ECG recordings were obtained with few exceptions. Single ectopic beats were noted in 3 subjects. The increase (i) in VO_2 and

TT at F on E testing suggests a "training" effect, slightly more in the Ex pts. The i VO_2 at ti, with less VE suggests more efficient utilization of oxygen in these pts. Thus, ESTF is apparent with THME in this initial group of CS pts with either a walk P or bicycle P.

Heart Rhythm and Conduction Analysis in Healthy Runners.
J. Cook, G. Pilcher, B. Johnston, G. Fletcher, Emory University, Atlanta.

Previous reports have documented arrhythmias and conduction disturbances in trained healthy athletes. To determine the incidence of such abnormalities and the level of physical training at which they occur, we obtained 24-hour dynamic ECG (Holter) recordings in 80 healthy runners and non-runners ≤ 40 years of age. There was no history of cardiovascular disease in any of the subjects. Subjects were grouped according to the number of miles per week (mpw) they had regularly run during the previous 3 months. Group (G) I = 0-5 mpw; G-II = 6-15 mpw; G-III = 16-30 mpw; G-IV = > 30 mpw. Results are summarized below:

	G-I	*G-II*	*G-III*	*G-IV*
Participants	20	19	21	20
Mean age	28	31	33	31
Sex	M—2, F—18	M—14, F—5	M—19, F—2	M—17, F—3
Occ. EVB	6	8	6	9
Freq. EVB	0	1	1	1
HGVE	0	1*	1**	0
Occ. PAC	8	7	5	7
Freq. PAC	0	0	1	0
AVDR	1	1	2	0

Occ = 6 ectopics per minute (epm); Freq = >6 epm; EVB = Ectopic ventricular beat; HGVE = High grade ventricular ectopy; * = Paired EVB; ** = Five beat run of ventricular tachycardia; PAC = Premature atrial contraction; AVDR = Atrio ventricular dissociative rhythm.

In summary, there was no significant difference in the occurrence of arrhythmias or conduction disturbances in the different groups. There was a single couplet of ventricular ectopy in G-II and a five beat run of ventricular ectopy in G-III.

Mitral Stenosis: A Two Dimensional Echocardiographic Evaluation of Mitral Valve Orifice Area.
Paul L. Douglass, Stephen D. Clements, Jr., I. Sylvia Crawley, Emory University, Atlanta.

The purpose of this study was to determine if 2D echocardiography offers a reproducible, accurate, non-invasive method of measuring mitral valve orifice area. We studied 11 patients with mitral stenosis. Their ages ranged from 23-61 yrs. There were 8 females and 3 males. Two patients had pure mitral stenosis with only trivial mitral regurgitation. Nine patients had either significant mitral regurgitation or aortic valve disease. All patients underwent M-mode and 2D echocardiography within one week of cardiac catheterization. All catheterizations were performed using the percutaneous Seldinger technique. Cardiac outputs were obtained using the Fick method, unless severe MR was present, in which case the angiographic stroke volume was used. Mitral valve areas were obtained using the Gorlin formula. All patients had cross sectional imaging of the mitral valve orifice. The black-white interface was traced and planimetered as the mitral valve orifice. Planimetry of the mitral valve orifice area from 2D echo compared favorably to the catheterization data with an r valve = .81. There was good correlation even in patients with severe mitral regurgitation and/or aortic valve disease. Although the final determinant for surgical intervention is cardiac catheterization, we conclude that two dimensional echocardiography provides a non-invasive tool for the serial measurement of the severity of mitral stenosis.

Diagnostic Value of Pain, Unequal Pulses, and Chest X-Ray in Acute Aortic Dissection.
R. R. Whitlock, A. M. Abdulla, M. Hughes, M. J. Frank, M.A. Stefadouros, Medical College of Georgia, Augusta.

In order to assess the diagnostic value of chest and/or abdominal pain, pulse deficit, and chest x-ray in the diagnosis of acute aortic dissection (AAD), we reviewed the medical records of 64 consecutive patients (pts) in whom the diagnosis was documented by aortography or autopsy. Eighteen pts had DeBakey Type I, 15 Type II, and 31 Type III AAD. Pain was present in all but 9 pts. Chest x-ray showed a widened mediastinum in 59% (61%, 33%, and 71% for Types I, II, III, respectively). Grossly unequal pulses were present in only 42% (50%, 33%, and 42% for Types I, II, and III, respectively). Aortography was performed in 43 pts, and the diagnosis was established in all but 2, in whom it was misinterpreted as showing a dilated aorta in one and severe atherosclerosis in the other. In 10 pts (16%), neither the chest x-ray nor the peripheral pulses were helpful, and the diagnosis was completely missed during life. We conclude that unequal pulses and widened mediastinum by x-ray may be absent in a significant number of pts with AAD. This emphasizes the need for a high index of suspicion and the importance of aortography in the evaluation of the acutely ill pt presenting with severe chest pain which is not attributable to other causes.

The American Heart Association-Georgia Affiliate Physician Hypertension Survey: Patterns of Hypertension (HT) Practice Among Georgia Physicians.
William McClellan, J. S. Wilber, D. Hall, S. Owen, Committee, Atlanta.

It is well established that treatment programs that achieve HT control can reduce the adverse consequences of HT. Successful HT treatment programs incorporate measurable components. To ascertain the degree that these components are included in the HT practice in Georgia, we conducted a 50% random survey of rural and urban Georgia physicians likely to encounter HT in their practice (N = 1335). A 63% response rate was obtained on a multiquestion survey of screening, diagnostic, therapeutic, and follow-up (f/u) practice. HT practice was ranked optimal or other (Table1).

HT Practice	*Optimal (%MD)*	*Other*
Screening	73.7	25.3
BP Measurement	66.3	33.7
Therapy Threshold	67-80	20-33
Drug Choice Step 1	74.1	24.9
Initial F/U	88-97	3-12%
Maintenance F/U	94-99	1-6%
Missed Appointment F/U	47.1	52.9

Of all areas, the use of f/u of missed HT appointments was least optimal. Given the role that therapy dropout may play in HT control, practice changes in this area may be desirable.

Value of the S3 Gallop in the Early Detection of LV Dysfunction in Patients with Chronic Aortic Regurgitation.

J. C. Hawkins, A. M. Abdulla, M. A. Stefadouros, M. J. Frank, Medical College of Georgia, Augusta.

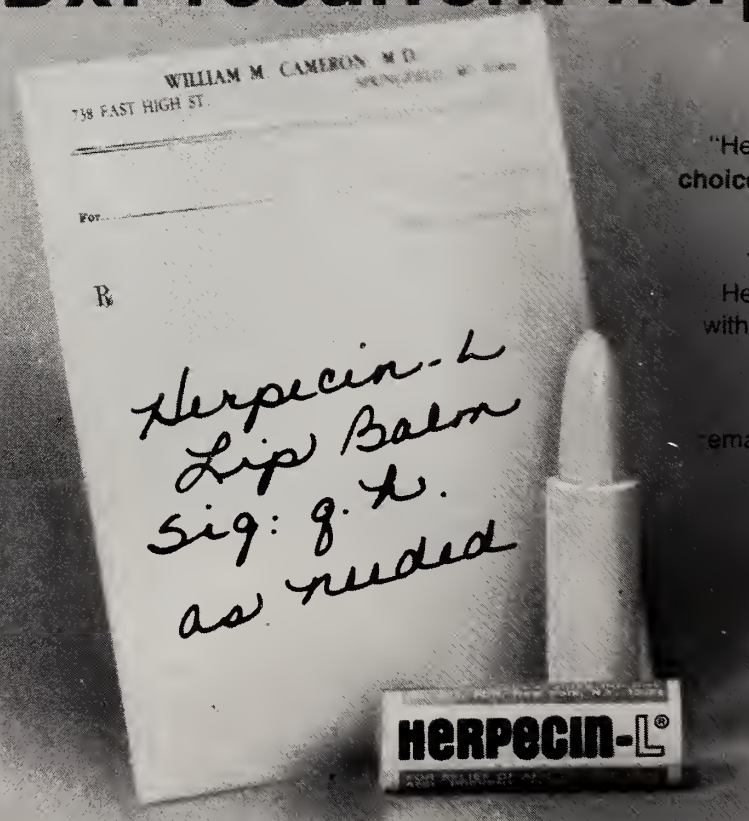
We have previously demonstrated that the S3 gallop in patients (pts) with significant chronic aortic regurgitation (AR) is associated with an expanded left ventricular (LV) end-systolic volume index (ESVI) and depressed contractility (LV systolic pressure/ESVI ratio). To evaluate the diagnostic value of a new S3 gallop in the bedside detection of early LV dysfunction, we followed 14 pts who had AR but no S3. Cardiac catheterization was performed on the basis of established clinical criteria, and the pts were examined at 6 months to yearly intervals. Four pts (mean age = 44 years, range = 29 to 69) developed an S3 and underwent a repeat cardiac catheterization. There was no significant change in the LV end-diastolic volume index or the severity of AR between the first and second studies. However, the ESVI rose from 35 ± 13 to 74 ± 10 ml/m^2 (mean ± SD), while the ejection fraction (EF) decreased from 0.78 ± 0.03 to 0.60 ± 0.05 and the contractility index fell from 5.26 ± 3.17 to 2.2 ± 0.31 mm Hg. ml^{-1}. m^2 (all $P < 0.05$). Although the EF was within normal limits in all 4 pts with an S3, the ESVI and contractility indices clearly differed from normal control values obtained in 31 pts (28 ± 7 ml/m^2 and 4.04 ± 0.55, respectively). In conclusion, this study supports our initial observation that the S3 gallop is valuable in the detection of early LV dysfunction in pts with AR.

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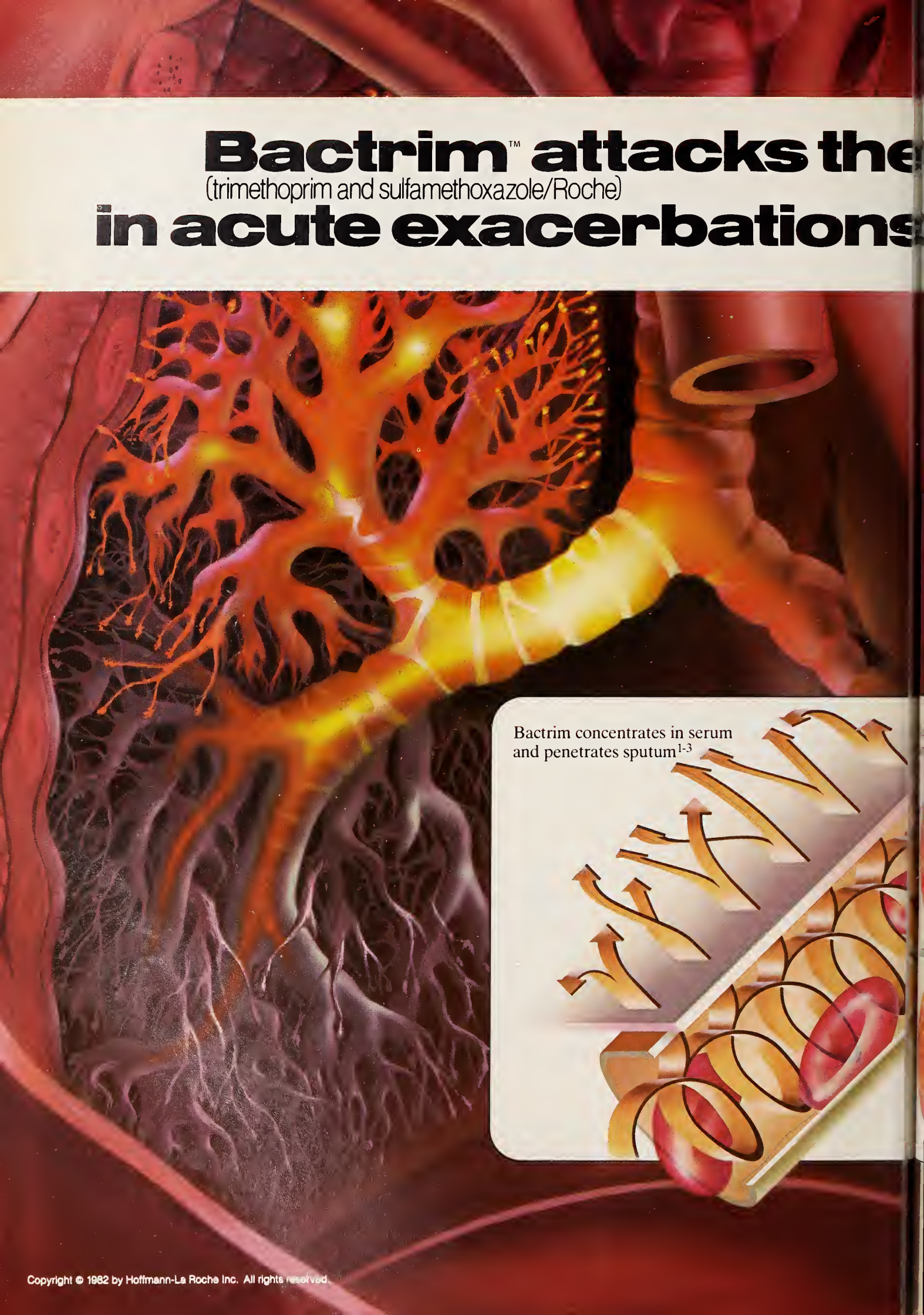
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J-9043-4 July 1981

Bactrim™ attacks the
(trimethoprim and sulfamethoxazole/Roche)
in acute exacerbations



Bactrim concentrates in serum and penetrates sputum[1-3]

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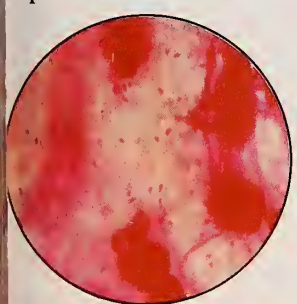
major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

acks *H. influenzae*—even mpicillin-resistant strains



attacks *S. pneumoniae*



Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection 6*(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

Economical b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. **Please see next page for summary of product information.**

Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Dr. McDowell describes the total freedom of being physically fit and capable of this exhilarating adventure.

He Climbed the Highest Coldest Mountain

EVELYN WARD GAY, ***Decatur****



Dr. Charles W. McDowell, Jr., climbed almost to the top of Mount McKinley in Alaska after many years of training and self-discipline to become physically fit.

"GOD'S WORLD WITHOUT MAN."

That is how Dr. Charles W. McDowell, Jr., describes the beauty and magnificence of snow-and-ice-covered Mount McKinley.

Last May, the DeKalb County ophthalmologist climbed the mountain for the first time to experience what he found to be "the most gorgeous sight" he had ever seen. He spent 2½ weeks on the "highest coldest mountain in the world," and came to within 8 hours of reaching the top before being stopped by a violent storm.

"The intriguing thing about all this is the total freedom of it," he says with enthusiasm. "It is the feeling of being self-contained. It's the same feeling flyers get in meeting the unknown. It's a totally different situation up there, a hostile environment."

Dr. McDowell believes that a healthy individual is one who is not dependent, who can function and survive under difficult circumstances, and he set out to prove that with the right survival skills, he could be such a person.

He became interested in physical fitness in 1970 when he saw himself getting out of shape from the sedentary life he was living after several years in medical practice. At first, he began with a program of weight lifting, rock climbing in north Georgia and North Carolina, and long distance running. The next phase was flying to Denver and climbing several mountains in Colorado and Wyoming. In Colorado, he says, there are over 50 peaks of 14,000 feet or more. One of his favorites was the Wind River Range in Wyoming, which is a part of the Rockies.

Each time he had completed one level of training, he moved on to something more extensive. The expedition to Mount McKinley was the culmination of almost 10 years of training and self-discipline, during which time he was able to lose 60 pounds of excess weight.

"The essence of all this is general physical conditioning," he stresses. "It is a feeling of wellness."

Wasn't it dangerous, and wasn't he afraid to climb Mount McKinley?

Yes, he answers, it was dangerous. A person can get killed climbing a mountain, but so can he get killed on the expressways. No, he was not afraid, because there was little time for that. He had confi-

* Mrs. Gay is a member of the auxiliary to the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.



Dr. McDowell, left, and his friend, Hank Holderfield, Executive Director of the DeKalb County Medical Society, left from this spot at Talkeetna, Alaska, to be dropped off on a glacier to begin their mountain climbing. They grew beards for protection from the cold.

dence in his ability to carry out his plan and felt only the excitement of the danger involved. Survival was uppermost in his mind during any difficult part of the climb, and it was only at night, when he had time to stop and think about it, that he contemplated the hazards he was undertaking.

Such strenuous exercise does tax the body, however. It definitely affects the physiology, he says, and pulmonary edema is common in mountain climbers. At such a high altitude and in −40 to −50 degree temperatures, a person deteriorates fast, and many people have problems with breathing. He also saw several people lose fingers and toes from frostbite.

The entire adventure was fatiguing, he said, although at age 47 he felt that he was in good physical condition. He suffered none of the problems which he saw in others, and attributed this to the long years of training which he had followed.

The trip was begun by flying to Anchorage, Alaska, and then driving to a small town called Talkeetna. From there he flew in a ski plane to a glacier where he was to start the climb. On the way up the mountain he was accompanied by a friend to whom he was secured by 150 feet of rope, and the two of them carried 300 pounds of equipment. Each was responsible for 150 pounds, 75 in a backpack and 75 on a sled which he pulled. In addition to this, each wore a body harness and 5 layers of clothing.

On the lower levels they wore snow shoes. On the more treacherous slopes they wore metal devices called crampons on their boots to grasp the ice, and had ice axes with points on the bottoms, and picks and choppers. On the steeper areas they used ice screws.

Even with all this preparation to try to prevent accidents, they got into some tight places. Dr. McDowell fell several times into unexpected crevasses that dot the mountain. Once he fell chest-deep and only his sled helped him to hold on until he could hoist himself out.



To lighten their load, the climbers placed some of their food in plastic bags and buried it along the way, marking the spot with willow wands with flags on the top so that they could locate it when coming down the mountain.

They ate well on the climb, he says. They carried 3 gallons of fuel and did their cooking on a gas stove. Dried food in foil packages was prepared by boiling it after melting snow to obtain water, and they were able to have a varied menu, including plenty of rice, noodles, and mashed potatoes. They even baked bread and cakes in a small oven that resembled a bundt pan. But when they came down, they had a hearty meal cooked by someone else. During the 2½ weeks they were on the mountain, he lost 14 pounds.

Dr. McDowell and his friend were proficient at map reading, but the mountain was always changing. Extremely fierce weather, including high winds up to 100 miles an hour and blizzards, were constant threats to their safety. They saw one German team's camp being evacuated by helicopter because of a storm.

When Dr. McDowell and his companion reached a height of 17,200 feet and were close to their goal, they became locked into their tent by a storm and had to spend 3 days there. Coming down finally to 14,500 feet, they had to stop for another 36 hours. One of the steepest slopes on the mountain, he said, was a distance of 2000 feet straight up between the 14,500 and 16,500 levels.



Each man carried a 75-lb. backpack and pulled a 75-lb. sled behind him.

It was a thrill, Dr. McDowell says, to be in an area where very few people will ever go. Mount McKinley, located 200 miles from the Arctic Circle in south central Alaska, and 2400 miles farther north of Mount Everest, rises from the Alaska Range 20,320 feet above sea level and more than 17,000 feet above the timber line. The snow line is at the 7,000-foot level, and above that the ice and snow cover the mountain year round.

Many years ago, the natives called the mountain Bulshaia, Traleika, or Denali (meaning "great"). The first white men to see the mountain were Captain James Cook and George Vancouver in about 1778. In 1896, it was named by W. A. Dickey in honor of William McKinley, 25th president of the United States, who served a first term from 1897 until 1901 before being assassinated just after beginning his second term in office.

Beginning in 1903, many attempts were made to climb to the top of the mountain. It was not until 1913 that Archdeacon Hudson Stuck and three companions succeeded in reaching the top of the highest southern peak. Less than 300 had climbed the mountain by 1970, says Dr. McDowell. In 1917, Mount McKinley National Park was created by an act of Congress. It covers 1,939,319 acres.

In recent years, the mountain has become a training ground for major climbers. Dr. McDowell says that these include Peter Habler, one of the two greatest climbers in the world. There were only three Southerners on the mountain when Dr. McDowell was there. A majority were international climbers who had scaled higher mountains in warmer climates, but none which could rival Mount McKinley as the highest coldest range.

Dr. McDowell has enjoyed sports of all kinds since his school days. A native Atlantan, he graduated from Decatur High School where he played football and basketball. He received his undergraduate education at Tulane University in New Orleans and his M.D. degree there in 1960. He then spent 3 years at the Victor Smith Memorial Eye Clinic in the same city before returning to Decatur to practice ophthalmology. He has two sons and one daughter. The older son is married and in the insurance business; the younger son is a senior at Auburn University. His daughter is an orthodontic technician.

When he is not practicing ophthalmology (which he does 6 days a week), or climbing mountains, Dr. McDowell enjoys sailing at Lake Lanier and playing golf and racketball. He also is involved in horse breeding, raising quarter horses for sale in Snellville. At the moment he has 23 horses.

In addition, he serves as chairman of the Public Relations Committee of the Medical Association of Georgia, is on the Board of Directors of the DeKalb County Medical Society and MAG, and is an alternate delegate to the state group from his county society.

Aside from accomplishing what he set out to do, Dr. McDowell views his experience at Mount McKinley as one which has given him a different slant on life. One becomes much more thoughtful about modern society, he says.

"It is striking," he concludes, "to come back and see how we litter and destroy our world."

Does he want to go back to Mount McKinley? His present plans are to return for a second try for the top in the spring of 1984.

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AN AFFILIATE OF HOSPITAL CORPORATION OF AMERICA

The author describes the medal which he designed to honor a diverse group of people who have contributed much to our state's heritage.

The National Medal Honoring Georgia on Her 250th Birthday

CHARLES B. UPSHAW, JR., M.D., ***Atlanta****

FEBRUARY 12, 1983, marked the 250th anniversary of the founding of Georgia. On that day in 1733, General James Oglethorpe and his group of English colonists landed at Yamacraw Bluff on the present site of the city of Savannah. Throughout 1983, there will be many celebrations marking this important and once-in-a-lifetime anniversary. One of the ways of honoring our state will be the issuance of a national medal minted by The United States Mint. A Resolution urging the production of such a medal was introduced on February 12, 1982, in the Georgia House of Representatives and Senate by Representative Denny Dobbs and Senator Don Ballard. The Resolution passed in both houses unanimously. It has been supported by all 10 of Georgia's U. S. Representatives and by both our U. S. Senators.

The suggested engraving on the medal may be described as follows: On the obverse side of the medal, there are three statuettes of King George II, Oglethorpe, and Tomochichi, with names written beneath each. On the upper periphery of the medal there is written 250th Anniversary Celebration; and on the lower periphery, Founding of Georgia. Across the lower obverse is inscribed 1733-1983. On the reverse side are small busts of nine persons who became outstanding Georgians; the last names are written beneath each bust. The state motto, Wisdom, Justice, Moderation, is written across the lower periphery of the medal. On the upper periphery is written United States of America. On the reverse are fifty stars honoring the fifty states of the union. These are arranged in two groups: 13 centrally placed stars in the form of St. Andrew's cross signifying Georgia as one of the thirteen original British colonies and American states; 37 peripheral stars representing the remaining states of the union.

Biographical sketches of persons appearing on the medal are listed below.

On the obverse side:

1) George II (1683-1760); born in kingdom of Hanover in Northwest Germany; soldier, King of Great Britain, from 1727-1760; chartered and gave his name to the colony of Georgia.
2) Oglethorpe: James Edward Oglethorpe (1696-1785); born in London, England; British General and philanthropist; founder of colony of Georgia.
3) Tomochichi: (about 1642-1739); Mico (Chief) of Yamacraw Indians; companion of Oglethorpe; friend and defender of colony of Georgia.

On the reverse side:

1) Carter: James Earl Carter, Jr. (1924-); born in Sumter County, Georgia; President of The United States of America; Governor of Georgia.
2) Berry: Martha Berry (1866-1942); born in Floyd County, Georgia. Educator, founder of Berry College in Northwest Georgia.
3) Gordon: John Brown Gordon (1832-1904); born in Upson County, Georgia; Confederate States General; Governor of Georgia; U. S. Senator.
4) Grady: Henry Woodfin Grady (1850-1889); born in Clark County, Georgia; journalist, editor of Atlanta Constitution; orator.
5) King: Martin Luther King, Jr. (1929-1968); born in Fulton County, Georgia; clergyman, Nobel Peace Prize recipient; leader of non-violent pro-

* Dr. Upshaw practices internal medicine. Send reprint requests to him at 35 Collier Rd., NW, Ste. 425, Atlanta, GA 30309.

gram for Negro equality.

6) Lanier: Sidney Lanier (1842-1881); born in Bibb County, Georgia. Poet, musician, author.
7) Long: Crawford Williamson Long (1815-1878); born in Madison County, Georgia. Physician, discoverer of anesthesia in surgery.
8) Mitchell: Margaret Mitchell (1900-1949); born in Fulton County, Georgia. Journalist, author of *Gone With The Wind,* Pulitzer Prize recipient.
9) Stephens: Alexander Hamilton Stephens (1812-1883); born in Taliaferro County, Georgia. Elected Governor of Georgia, U. S. Representative, U. S. Senator, Vice-President of Confederate States of America.

Thus, this honored and diverse group includes an English king, an Indian chief, a black man, two women, a president of the United States of America, a vice-president of the Confederate States of America, three governors of Georgia, two generals, two U. S. senators, one U. S. representative, two journalists, a clergyman, a poet, a physician, an author, and recipients of a Nobel Peace Prize and a Pulitzer Prize. Surely we in Georgia have been blessed and can be proud of our able men and women.

We are indebted to Representative Denny Dobbs of Covington for his untiring efforts on behalf of this medal. When the national medal is produced, it will be offered for sale to Georgians and others in our country in both silver and bronze forms. I urge each of you to support this undertaking by purchasing one or more of these historic medals honoring our great state.

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Now that we "know where we stand" with the public as a result of this survey, we can take appropriate action in those areas of concern to us.

The Public Speaks — Part IV

CHARLES W. McDOWELL, JR., MD., *Decatur,* **and KEN WILLIAMS,** *Atlanta**

THIS IS THE LAST in a series of articles on how the public views physicians. The Public Speaks — Parts I, II, and III appeared in the three previous issues of the *Journal*. The basis for this series was a public opinion survey conducted in August of last year. It was commissioned by the MAG Board of Directors at the request of the Public Relations Committee. To our knowledge, the survey was the largest ever conducted in Georgia on health care issues.

In this issue of the *Journal,* we shall focus on competition in medicine — the public's view, acceptance and changes in how medical care is delivered, physician advertising, the public's view of medical malpractice, and personal lifestyle and health.

Competition in Medicine

The public was polled on two issues relating to competition among physicians. The first concerns their opinions on the number of physicians in the community. The question and findings appear below. Please note, we are able to compare Georgians' answers with a national sampling taken in 1981 and 1982 with our own survey completed last August. The numbers are percentages of respondents answering a certain way.

Which of the Following Statements Do You Think Best Describes the Situation in Your Community Today With Respect to the Number of Doctors You Have?

	US *1981*	*US* *1982*	*GA* *1982*
There are not enough doctors with the result that many have more patients than they can comfortably handle	38	38	40
There are too many doctors, with the result that many MDs have fewer patients than they would like	10	7	8
The number of doctors is about right	47	52	49
Not sure	5	3	3

In Georgia, four out of 10 believe there are too few physicians. Only 8% believe we have a surplus of physicians. Public opinion on this topic differs strongly from physicians' views.

When we examine the respondents by race and education, 58% of nonwhites believe we have too few physicians, while only 26% of college graduates think physicians are too few in number.

The other question in the survey relating to competition in medicine asked about the source of where the public's medical care was delivered. The question and answers follow.

Some People Get Medical Care From a Personal Physician, While Others Go to a Hospital Clinic, Emergency Room, Outpatient Clinic, or a Public Health Department for Routine Medical Care. In the Past Year, Have You Obtained Medical Care for Non-Emergency Problems Through Any of These Sources That Don't Involve Going to a Personal Physician?

	US	*GA*
Yes	25	24
No	74	76
Don't Know	1	0

Please note, the question concerned non-emergency problems. Almost one fourth of those asked got their care form other than a personal physician. When we examine the data of who these persons are, we find that the 24% were mostly young (18-34 years of age), or old (65+ years of age), non-white, and poor (earning less than $10,000 a year).

However, one in five individuals earning $30,000 or more and having a college degree also reported clinic use. The general pattern is one of fairly even

* Dr. McDowell practices ophthalmology and is Chairman of MAG's Public Relations Committee; Mr. Williams is Director of Public and Professional Relations for the MAG. Send reprint requests to Mr. Williams at 938 Peachtree St., NE, Atlanta, GA 30309.

dispersion across demographic categories. This suggests that over time, use of hospital outpatient services is increasing among population subgroups that formerly had not used these facilities. This is clearly a major competitive threat to physicians in more traditional forms of practice.

Changes in Medical Care Delivery

Another portion of our survey concerned acceptance of changes in medical care delivery. As concern over health care costs has grown, changes in medical care delivery have been proposed and, in certain cases, implemented to control costs. These new forms of practice prosper or fail principally on the basis of public appearance.

We inquired of our more than 400 respondents what they felt about some possible changes in how medical care is delivered. Georgians' answers are compared to a national sampling conducted by the American Medical Association.

The question we asked on this subject appears below along with the answers.

As you can tell from the answers, the high percentages in the "strongly approve" and "strongly disapprove" categories indicate that this is a polarized emotional issue.

The greatest objections to change are in the areas of longer waiting times for appointments (71% strongly disapprove); giving up the right to sue for possible malpractice (69% strongly disapprove); and giving up the right to see a specialist unless the total costs were borne by the patient (66% strongly object).

Surprisingly, a majority of Georgians do not object to seeing a trained assistant rather than a doctor for certain problems. However, a majority of Georgians do object to giving up a personal physician for a clinic situation.

Although giving up the right of self-referral to a specialist is strongly opposed, many health maintenance organizations (HMOs) include this feature. It is quite possible the public is simply unaware of this aspect of HMO enrollment.

When we compare Georgians' resistance to these suggested changes, we find a higher resistance in our state than in the national sampling. The demographic breakouts show additional interesting differences. In Georgia, among those aged 35-44 (considered the prime earning years), there is substantially higher support for all the proposed changes than in the U.S. as a whole.

Physician Advertising

We asked a number of questions related to physician advertising. As a result of recent rulings by the Federal Trade Commission and the Supreme Court, much attention has been focused on the issue of professional advertising. In estimating the impact of these decisions on medicine, it is useful to determine the public's reaction to increased advertising by physicians. The first question we asked on this subject appears below along with the answers.

Aside From Telephone Book Listings, Have You Seen or Heard Any Advertising By Physicians or Groups of Physicians?

	US	*GA*
Yes	28	27
No	71	73
Not Sure	1	0

Reaction to physician advertising is an area in which Georgia residents differ substantially from the U.S. population. In almost every instance, responses from Georgia *are more negative:*

—8% more see advertising as unethical
—5% more agree that good doctors will not advertise
—6% more agree that ads make doctors less professional
—4% more (to 37%) would think less of their physician if he/she began to advertise.

In the Future, We May Be Asked to Make Some Changes in Our Medical System to Control Costs. I Am Going to Read Some Changes and For Each, Tell Me Whether You Would Approve Or Disapprove of Such a Change. Do You Feel Strongly About This?

	Strongly Approve		*Approve*		*Disapprove*		*Strongly Disapprove*	
	US	*GA*	*US*	*GA*	*US*	*GA*	*US*	*GA*
Rather than having a personal doctor you would be treated by one of a group of doctors, like a clinic	23	24	23	16	10	11	43	48
For certain problems you would not see a doctor but rather a trained assistant	32	36	22	15	8	9	37	40
You would have to wait longer to get an appointment than you usually do	10	12	8	7	15	10	66	71
You would have to wait longer to schedule non-emergency hospitalization	25	26	22	20	13	9	39	43
You would give up the right to sue for possible malpractice	15	14	8	6	12	10	64	69
You would give up the right to see a specialist whenever you wanted unless you paid all the cost yourself	16	20	8	7	11	6	64	66

We have asked a series of agree/disagree questions. Below are the questions and answers.

Please Tell Me If You Agree or Disagree With the Following Statements About Advertising By Doctors.

	Agree GA	*Disagree GA*
It is ethical and proper for doctors to advertise	57	43
Advertising will increase competition among doctors for patients	65	35
Good doctors will not advertise	54	45
Increased advertising will lead to lower doctors' fees	38	61
Advertising makes doctors less professional	37	63
Advertising will promote better doctor-patient relations	28	70
Advertising by doctors will be truthful and honest	35	63
Advertising will help people in choosing a doctor	61	38
You would think less of your doctor if he or she began to advertise	37	63
A doctor who advertises is in effect saying he or she isn't very successful	34	66

In summary, the public believes that physician advertising:

—is ethical and proper
—will increase competition for patients
—will not reduce physicians' professionalism
—will help people choose a physician
—will not affect existing patient's evaluations
—is not a sign of unsuccessful practice.

The public also tends to feel that advertising:

—will not be done by "good doctors"
—will not reduce fees
—will not promote better physician-patient relations
—will not be truthful and honest.

Reaction to physician advertising is an area in which Georgia residents differ substantially from the U. S. population as a whole.

While a majority disagrees, one third of the public indicates they would think less of their physician if he/she advertised and more than a third continue to believe that physician advertising is unethical and improper.

Medical Malpractice

Malpractice claims and judgments are rising rapidly with an inevitable upward pressure on malpractice insurance premiums. For this reason, malpractice and related topics were included in our recent survey. The three questions we asked and the corresponding answers appear below:

As You No Doubt Know, There Have Been a Lot of Cases Recently Where People Have Sued Doctors for Malpractice. Do You Think People Who Sue Physicians for Malpractice Are Usually Justified in Bringing Suit, or Are They Just Looking for an Easy Way to Make Some Money?

	GA
Usually justified in bringing suit	43
Just looking for easy way to make money	46
Not sure	11

Do You Think the Amount of Money Awarded to Patients By Juries in Malpractice Suits Is Usually Too Much, Not Enough, or About Right?

	GA
Too much	43
Not enough	8
About right	42
Not sure	7

Do You Think That There Should Be a Limit on the Amount of Money That Can Be Awarded to Someone Suing a Doctor for Malpractice?

	GA
Yes	60
No	37
Not sure	3

A majority of Georgians do *not* believe that people who sue for malpractice are usually justified in bringing suit. Further, a surprising percentage (43%) state that current awards are too high, while only 8% believe that not enough money is usually awarded. Finally, a strong majority favor limits on malpractice awards.

In combination, these figures indicate surprisingly strong pro-physician views on malpractice-related issues. The extent to which these views can be translated into legislative reality perhaps should be further explored.

Lifestyle and Health

There were a number of questions in the questionnaire relating to personal lifestyle and health. We wanted to know how aware the public is that certain lifestyles directly affect health, and if they are aware of the relationship, have they made the appropriate behavioral changes. The questions asked on this subject appear below along with the respondents' answers.

There are several habits that approximately one-third of the public does not believe to be health-related. These are:

—reducing fat, red meat, and dairy products intake
—using health or organic foods
—taking vitamins or food supplements

Twenty-five percent of those Georgians polled

There Has Been a Lot of Discussion Recently About the Relation Between Personal Habits and Health. Do You Believe That . . . Is a Healthy Thing to Do, or Is It Not Related to Being Healthy?

	Healthy Thing to Do GA	*Not Related to Being Healthy GA*
Cutting down on the amount of fat, red meat, or dairy products we eat	63	32
Reducing the amount of salt we consume	87	10
Exercising vigorously at least two or three times a week	88	10
Increasing the amount of fiber or bulk we eat	82	15
Using health foods or organic foods regularly	45	52
Taking vitamins or other food supplements regularly	61	36
Refraining from smoking cigarettes or smoking only in very moderate amounts	88	11
Maintaining a body weight that's neither too high nor too low	92	7
Consuming alcohol only in moderation	74	25

For Each Item Answered "Healthy Thing To Do" Have/Do You . . .

	Yes GA	*No GA*
Cut down on the amount of fat, red meat, or dairy products you eat	80	20
Reduced the amount of salt you consume	80	20
Exercise vigorously at least two or three times a week	65	34
Increased the amount of fiber or bulk you eat	63	37
Use health foods or organic foods regularly	45	55
Take vitamins or other food supplements regularly	67	33
Refrain from smoking cigarettes or smoke only in very moderate amounts	86	14
Maintain a body weight that's neither too high or too low	80	20
Consume alcohol only in moderation	90	9

believe that excessive alcohol consumption does not effect health. Interestingly, the most unanimous choice in staying healthy is keeping a body weight that is neither too high nor low. Curiously, 12% of the respondents still see no link between cigarette smoking and health.

The second set of questions gives a more accurate reading on *actual changes in behavior to improve health*. Over one third of Georgians, *who say these habits are healthy,* do not:

—exercise
—increase fiber/bulk intake
—use organic/health foods
—take vitamins.

And, one in five, *who again are aware of the negative health impact,* do not:

—reduce fat/red meat/dairy products intake
—reduce salt consumption
—reduce or quit smoking
—maintain appropriate body weight.

Finally, one in ten continues to consume excessive amounts of alcohol even though they are aware of negative health consequences.

The relationship between the two tables tells exactly how much lifestyle improvement can be expected from public education. The results show that in some cases, the number of Georgians who have poor habits and *know they are unhealthy* is as great as those who are simply unaware of any health linkage. Increased peer and occupational pressure to change are two ways that may affect the former group. Public education will hopefully motivate the "unawares" to become more health conscious.

In Summary

As a result of the survey last August, we now know, with some certainty, Georgian's views on:

—the main problems facing their health and medical care
—the priority they give to health care
—the preferences they have in the way medical care is delivered to them, i.e., private physician vs. other providers
—their satisfaction with their personal physician
—their method of choosing or retaining their physician
—the malpractice situation and whether limits should be set on awards
—the physicians' image
—their ability to pay medical costs
—who is responsible for rising health care costs
—physician advertising
—personal lifestyles and health

Now that we "know where we stand" with the public, our patients, we can take appropriate action in those areas of concern to us. Unfortunately, there is no magic wand that will enlighten the uninformed, restore lost confidence and respect, or convince everyone that a physician's first concern is the welfare of his patient regardless of his ability to pay.

We will be judged on our actions, not on our good intentions. Each of us must decide how important public opinion is to us. Once that decision is made, each of us must decide what commitment he is prepared to make to improve medicine's respect.

The Public Relations Committee is proposing to MAG's House of Delegates a 1983-84 PR budget approaching $100,000. We believe it is unfortunate that such an expenditure of your dues money is

necessary. But we do believe that such an expenditure is not only necessary but will only begin to improve the physician image and to market the private practice of medicine as defined by the MAG Medical Practice Committee.

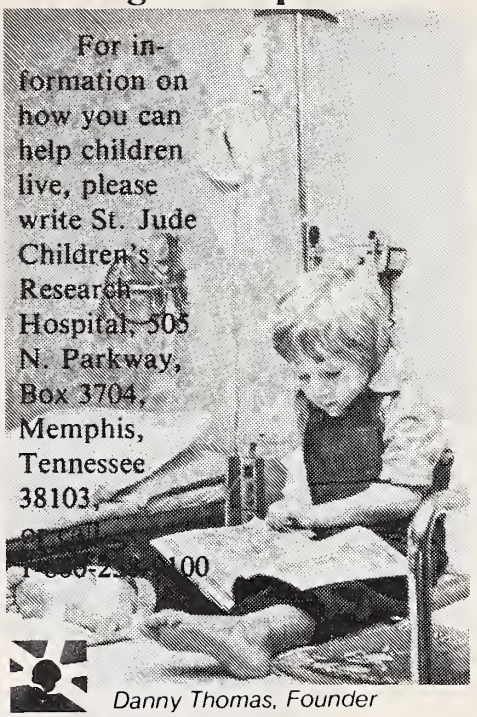
Ultimately, it will be individual physicians from Clayton to Bainbridge, from St. Mary's to Dalton, that will decide the public's view of medicine and those who practice it.

Survey results indicate surprisingly strong pro-physician views on malpractice-related issues.

If each of us will take one minute to consider the importance of what has just been stated, we are on our way toward making our profession worthy of the utmost respect and admiration. The funds to be expended represent approximately one office visit per physician per year.

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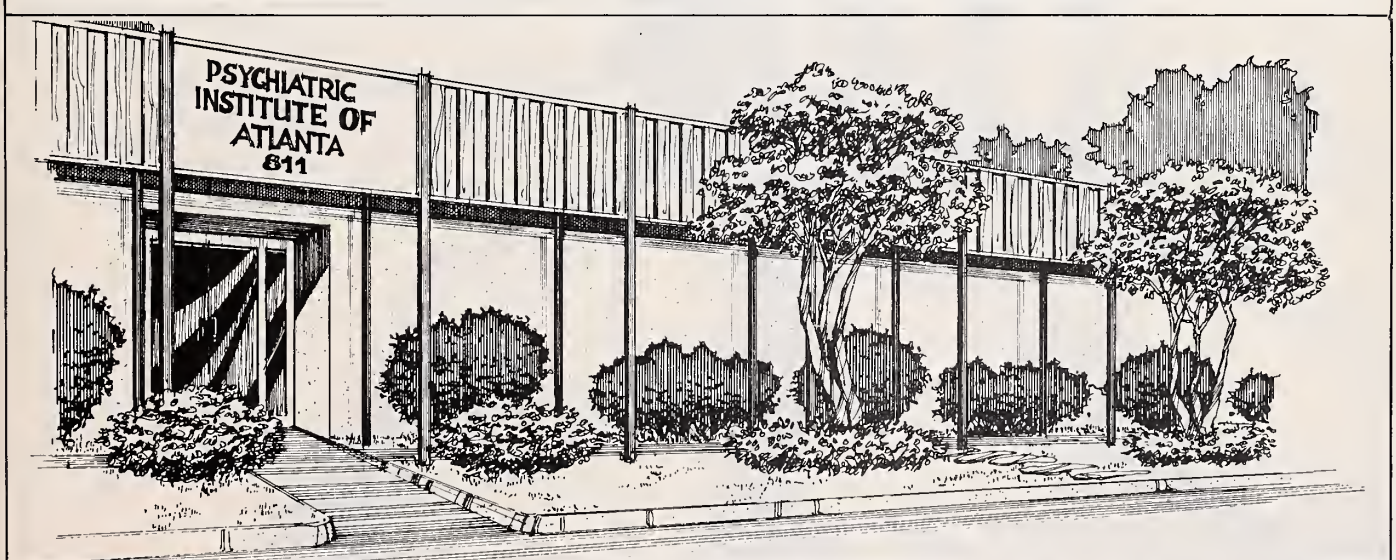


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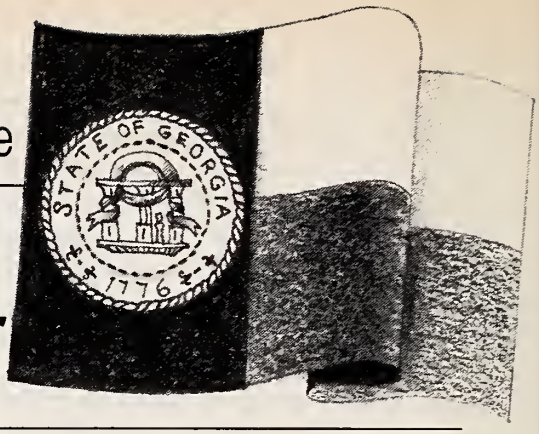


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Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

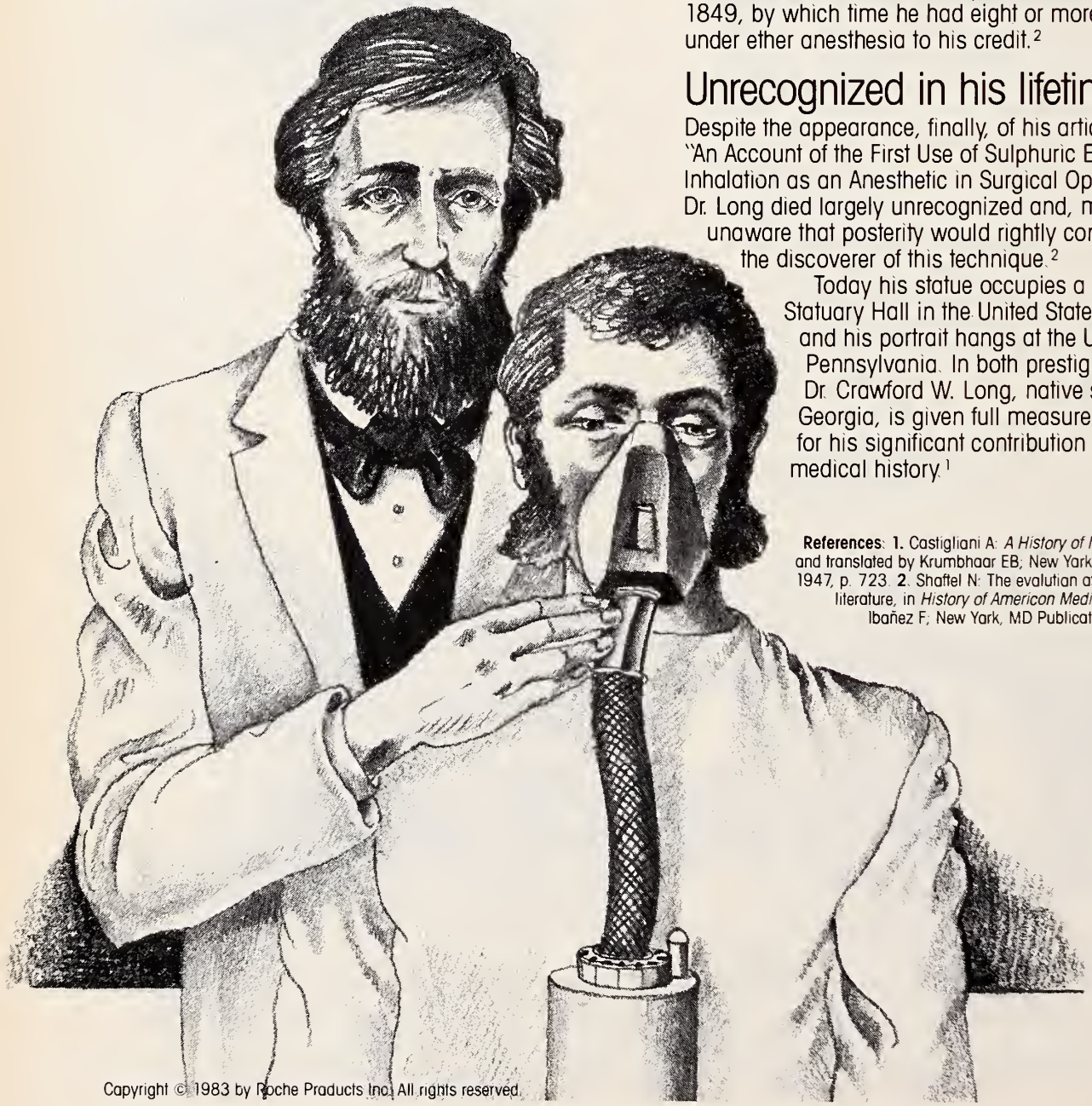
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Castigliani A: *A History of Medicine,* edited and translated by Krumbhaar EB; New York, Alfred A. Knapf, 1947, p. 723. **2.** Shaftel N: The evalutian af American medical literature, in *History of Americon Medicine,* edited by Marti-Ibañez F; New York, MD Publicatians, 1959, p. 107.

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Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

In another multicenter study,[3] the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

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- ☐ Early insomnia—91%
 Middle insomnia—87%
 Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of onxiety, in *Psychophormacology in the Practice of Medicine,* edited by Jorvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et ol: Psychophormocology 61:* 217-229, Mar 1979. **3.** Data on file, Hoffmonn-La Roche Inc., Nutley, NJ.

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Please see summary of product information on following page.

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Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
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Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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Student interest in national issues affecting health care and in organized medicine are enhanced by students' participation in this meeting.

Medical Students' Report on the 1982 AMA Interim Meeting

KAROLYN KRAMER, *Augusta,* **SUSAN MIDDLETON, and LEON DENT,** *Atlanta**

On December 3, 1982, at the Fountainebleau Hotel in Miami Beach, the Medical Student Section (MSS) of the American Medical Association, (AMA) convened for its 1982 Interim meeting. With 140 students present, 90 of the nation's allopathic and osteopathic schools were represented in the MSS Assembly. In spite of blue skies, white beaches, and numerous hospitality suites, many issues were debated, with 12 resolutions finally hammered out to present to the AMA. Student input into the AMA-sponsored project, "Health Policy Agenda for the American People," was also the subject of much testimony at one of the reference committees. The following is a summary of the resolutions passed by the MSS Assembly for consideration by AMA reference committees and the Board of Trustees.

Issues Debated

As always, issues in public health and preventive medicine were of great concern to the MSS Assembly. The Assembly supported a study on pneumococcal, influenza, and hepatitis vaccine released by the AMA Council on Scientific Affairs in response to a resolution introduced by the MSS Assembly at the annual 1982 meeting. The pneumococcal and influenza vaccines were recommended for populations at risk (especially the aged and chronically ill), and it was noted that the pneumococcal vaccine is the only vaccine covered by Medicare. The council reported that the hepatitis B vaccine has so far proven effective in the high risk populations to whom it has been administered. Expert testimony was heard concerning the possibility that since the vaccine is derived from the serum of high risk individuals, it may contain contaminating agents which are linked to acquired immunodeficiency syndrome (AIDS) and Kaposi's sarcoma. Although no evidence confirming the presence of contaminating agents exists, widespread use of the vaccine is cautioned against until safer, artificial hepatitis B antigens can be developed.

The MSS Assembly also urged the AMA to support the continued use of pertussis vaccine, but recognizing that there may be adverse effects with the current antigen, encouraged development of improved vaccine. This resolution was sparked by concern over recent small outbreaks of pertussis among children who had not been immunized because parents believed the possibility of adverse effects was too great to "risk" immunizing their children. MSS encourages physicians to participate in educating the public about the need for standard childhood immunizations.

The distribution of free cigarettes was a matter of concern to MSS members who voted to encourage the AMA to endorse legislation that would prohibit the distribution of free cigarettes on public property.

Other health policy concerns addressed by MSS included the continued opposition to regulations that require parental notification when prescription contraceptives are provided to minors.

Impaired Physicians and Related Topics

Another topic of serious interest among students was physician impairment. Four resolutions were passed by the Assembly in an effort to present to the AMA specific ideas regarding treatment and educa-

* Miss Karmer is from the Class of 1984, Medical College of Georgia; Miss Middleton and Mr. Dent are from the class of 1985 at Emory University Medical School and the School of Medicine of Morehouse College, respectively. Send repring requests to Miss Kramer at MCG School of Medicine, Box 609, Augusta, GA 30912.

tion about impairment. One resolution requested the AMA to sponsor distribution of the manual, *Beyond Survival*, written by the Resident Physician Section (RPS) for both professionals with problems and for peers who might be doing the confrontations. The MSS felt this would be valuable to third and fourth year medical students, since development of adequate and appropriate coping skills and behaviors during training is one of many ways in which impairment later might be prevented. Also, many physicians-in-training are unaware of literature that addresses this subject and of the unique stresses that the profession of medicine may place on the physician and the physician's family. According to J. H. Pfifferling, Ph.D., co-director of the Center for Well-Being of Health Professionals in Durham, N.C., " . . . (the) medical culture pressures doctors to maintain a professional facade at all times, and offers few educational and behavioral tools for dealing with a lifetime of dispensing hope from a single energy source."[1] The AMA adopted the resolution, amended to provide the book at cost to each student.

Another resolution reasoned that well-being programs taught by physicians who have personally experienced difficulties are valuable mechanisms for illustrating the relevance of impairment; it therefore asked the AMA to urge state medical societies to approach medical schools to organize and lead discussion programs. Georgia is fortunate to have one of the nation's top rehabilitation centers, Ridgeview Institute in Smyrna. Dr. Douglas Talbot, its director, speaks regularly to Emory medical students. The MAG may want to tap this resource, as well as encourage other Georgia medical schools to devote more time to this subject.

A third resolution specifically recognized alcoholism as a serious problem among medical students and house staff. It requested the AMA to encourage medical schools to set up student/faculty referral groups, to identify alcohol and drug treatment programs that meet the unique needs of medical students, and to grant leaves-of-absence to addicted students, after which reinstatement could occur.

Finally, the MSS asked the AMA to establish a National Steering Committee on Well-Being, whose purpose would be to promote and facilitate the development of well-being programs for use in medical schools, and the expansion of existing programs to include medical students.

Financial Concerns

Financial aid is an ongoing concern to most medical students. Reasons for this interest are that tuition is rising very rapidly and the Reagan Administration is continuing its assault on federal loan programs. This concern is exemplified by the many MSS Resolutions and Governing Council Report dealing with student financial aid.

MSS Resolution 1 — Health Education Assistance Loan

Resolution 1 asks the AMA to support continuing of the HEAL program at a level equal to or exceeding the previously authorized limit of $225 million for 1983; to support an increase in the limit on the volume of HEAL loans at a rate adequate to accommodate the unmet needs of medical students.

MSS Resolution 3 — Guaranteed Student Loans

Resolution 3 asks the AMA to oppose measures to eliminate the GSL program and to oppose attempts to limit graduate student eligibility for this loan program until such time that reasonable alternatives for providing adequate financing at a manageable cost for all students become available.

Testimony in reference committees revealed that current AMA policy is already in agreement with these resolutions. The AMA has already demonstrated through written communication and testimony to Congress its opposition to cutbacks in medical student financial aid. Thus, the intent of resolutions 1 and 3 will be achieved through the MSS Governing Council working with the appropriate AMA units.

Resolution 2 — Physician to Student Loans

Resolution 2 asked that the AMA urge state medical societies to develop a model package of materials providing guidelines for terms and conditions of direct physician to student loans. This would provide reasonable conditions and protections for both borrower and lender and enable physicians and students to consummate loans without incurring significant additional legal debt.

Resolution 4 — Loan Refinancing and Consolidation

The MSS Ad Hoc Committee of Financial Aid was asked to explore loan refinancing and consolidation programs available to medical students and publish this information as soon as possible in *Pulse*. In addition, this committee is publishing a pamphlet on debt management.

Redirection of AMA-ERF Funds to a Financial Assistance Program for Medical Students

The AMA-Education and Research Foundation (ERF) accepts contributions from a number of sources, mostly state and county medical societies and their associated auxiliaries. AMA-ERF distributes money to medical schools and state medical societies with no strings attached. That is, the school

may use the funds for whatever reasons it deems necessary, e.g., faculty salaries, curriculum development, facilities, or student aid. Unfortunately from the student perspectives, there is no way to guarantee that any of the funds will be allocated toward student aid. At the annual 1982 meeting, the MSS commended the Illinois State Medical Society for redirecting one-half of its funds for the AMA-ERF to financial assistance programs for medical schools. It has since been learned that the AMA-ERF will soon begin administering a new student loan program. There is a fear among students that the state societies may no longer feel it necessary to set up their own student loan foundations, since the money collected for these programs could simply be donated to the new AMA-ERF loan program. This action could even be counter productive since the resultant increase in administrative cost would divert badly needed dollars from the loan disbursements. The MSS is evaluating the success of the new Illinois AMA-ERF student loan program before encouraging other state medical societies to establish similar programs.

This concludes the report from the Georgia student delegation on the AMA's Medical Student Section Interim '82 meeting. Once again, we would like to express our appreciation to the Medical Association of Georgia for sponsoring one student delegate from each medical school. This opportunity not only broadens our medical education individually, it allows us to educate our peers on national issues of student interest and on the benefits of being involved with organized medicine.

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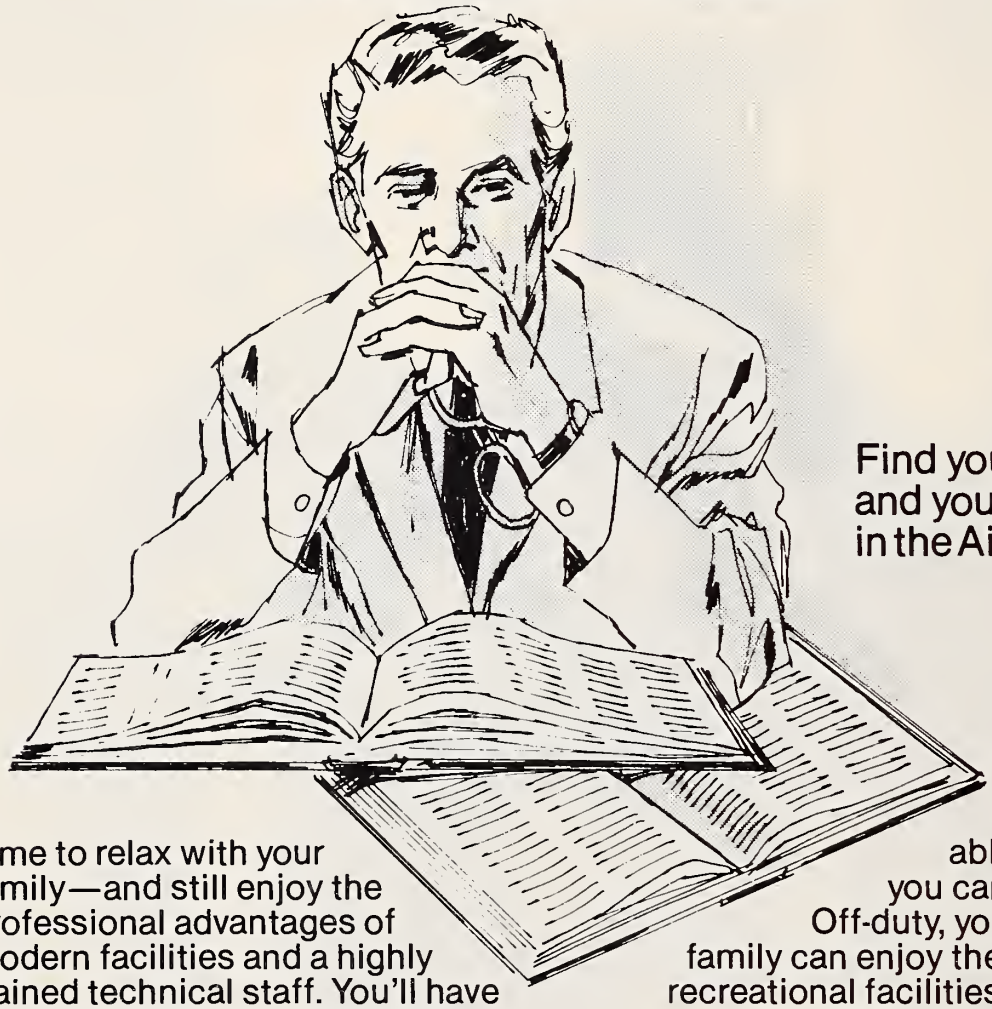
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During the preparation of a patient for surgery, a preoperative respiratory evaluation should be designed to identify potential risk factors which increase the incidence of postoperative complications.

Pre- and Postoperative Respiratory Care

JAMES J. WELLMAN, M.D., *Atlanta**

In the last decade, the widespread application of applied pulmonary physiology has focused attention on the patient's preoperative respiratory status and on methods for improving pre- and postoperative lung function. With the advent of these principles and an increasing number of operations on high-risk patients, surgeons and medical subspecialists are becoming more involved in pre- and postoperative management.

Respiratory Complications of Surgery

Respiratory complications are among the most common causes of postoperative morbidity and mortality and are estimated to occur in 5% to 7% of patients undergoing surgery.[1] Approximately 25% of all postoperative deaths are due to respiratory insufficiency and in an additional 25%, respiratory dysfunction is a concomitant factor contributing to death.[2]

Atelectasis, which derives from the Greek meaning "imperfect expansion," is the most common postoperative respiratory complication. The severity of atelectasis can range from involvement of a small group of airways and alveoli to complete collapse of an entire lung. Atelectasis has been estimated to be responsible for approximately 90% of all postoperative respiratory complications.[3]

Table 1* lists some of the other common postoperative complications. These complications are defined by the appearance of radiographically visible pulmonary infiltrates, abnormal arterial blood gases, and one or more of the following clinical observations: wheezes, rhonchi, rales, and rapid, shallow respirations with an ineffective cough response. These changes are accompanied by fever, restlessness, increased pulse rate and systemic blood pressure, increasing shortness of breath, and the appearance of purulent material in tracheobronchial secretions.

Table 1 — Common Postoperative Respiratory Complications

Atelectasis
Retained tracheobronchial secretions
Increasing airways obstruction (bronchospasm)
Bronchitis and pneumonia
Hypoxemia with/without hypercarbia
Pulmonary hypertension, cor pulmonale, and right ventricular failure
Pulmonary thromboembolic disease
Respiratory failure requiring mechanical ventilation

Clearly, these descriptive changes do not represent all the ways respiratory complications can manifest. For instance, the elderly patient who develops a pulmonary infection postoperatively may not demonstrate fever, leukocytosis, or radiographic infiltrates. Furthermore, if tracheobronchial secretions become viscid and the cough mechanism is depressed, such material is often not expectorated and consequently purulent sputum is not apparent to the clinician. Prior to the more common use of arterial blood gases, the above clinical observations failed to include alveolar hypoventilation, a complication that leads to hypercapnia, hypoxemia, and respiratory acidosis.

Risk Factors for Respiratory Complications

The development of postoperative respiratory complications depends upon a number of factors

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This paper was prepared at the request of the Georgia Thoracic Society.

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Table 2 — Factors Contributing to Postoperative Respiratory Complications

Pre-existing respiratory disease
Type of operation
Depression of mucociliary activity
Duration of anesthesia
Advancing age
Obesity
Smoking
General physical and mental condition

(Table 2*). The incidence of postoperative respiratory complications among patients with chronic obstructive pulmonary disease is increased. Approximately 70% of patients with abnormal pulmonary function studies and a compatible history of obstructive lung disease will develop postoperative complications.[4]

The type of surgery influences the respiratory complication rate. The nearer the incision to the diaphragm, the greater the reduction in pulmonary function postoperatively. During tidal breathing, the expiratory phase is passive; but with an increase in airways resistance such as seen in patients with obstructive lung disease, upper abdominal muscles, which are muscles of expiration, participate actively. Consequently, the degree and extent of abdominal muscle injury directly influences the postoperative pulmonary complication rate.

Atelectasis has been estimated to be responsible for approximately 90% of all postoperative respiratory complications.

The use of cuffed endotracheal tubes and dry anesthetic gases tends to suppress the clearance of mucus by altering the ciliated epithelium and by changing the rheologic properties of the mucus. These factors may often be potentiated by preoperative dehydration, fasting, and the inhibition of bronchial gland secretion by atropine. Slowing and even cessation of the mucociliary transport may exist in the postoperative period for up to 6 days, and this abnormality correlates with the duration of operation.[1] The lack of coughing and deep breathing during the operative procedure and in the postoperative period results in retention of mucus in the airways and is associated with an increased incidence of lobar and segmental atelectasis. These factors all promote an invasion of the lower respiratory tract by bacteria which usually reside in the upper airway. These risks are enhanced by the presence of diseases which promote an excessive amount of tracheobronchial secretions such as bronchiectasis, acute and chronic bronchitis, and bronchial asthma.

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Other factors which contribute to increased respiratory complications are the duration of anesthesia,[2] advancing age,[5, 6] obesity[7, 8] and cigarette smoking.[9, 10] It has been estimated that smoking more than 20 cigarettes a day is associated with at least a fourfold increase in the incidence of postoperative atelectasis.

The general medical condition and the nutritional status of the surgical patient are important factors in perioperative complications and their management. Obviously, patients with pre-existing medical illnesses such as diabetes, heart disease, and peptic ulcer disease are more susceptible to the stress of general anesthesia and surgery; and a poor nutritional state predisposes to a depressed ventilatory response and delayed healing.

The patient's emotional stability and anxiety level help determine how pain is perceived and therefore how much pain he is willing to endure in a postoperative respiratory therapy program.[11, 12] Postoperative pain promotes a monotonous, shallow breathing pattern and suppression of the cough response, which consequently favors respiratory complications. The analgesic requirement can often be reduced 50% or more by instruction of the patient and by rapport with physicians, therapists, and nurses.[13, 14]

Preoperative Respiratory Evaluation

During the preparation of a patient for surgery, a preoperative respiratory evaluation should be designed to identify potential risk factors which increase the incidence of postoperative complications. The identification of respiratory disease is no guarantee that complications will not arise; however, many postoperative complications arise when the physician is not cognizant of the potential risk factors. Unfortunately, many patients seen in the intensive care unit with respiratory complications have had an inadequate preoperative evaluation, and the seriousness of preoperative respiratory dysfunction was not recognized. Once the potential risk factors have been identified and quantitated, a plan can be formulated that will either prevent such complications or minimize the adverse physiologic consequences.

The routine history is essential but not always reliable in predicting which patient will experience postoperative respiratory problems. The history should be conducted with an increased index of suspicion to notice factors which may lead to distress during and after surgery. Table 3* offers some specific historical points that should be assessed prior to the surgical procedure.

A physical examination can often provide clues to potential respiratory disease. The obvious red flags of dyspnea at rest, tachypnea on slight exertion, and

Table 3 — Pertinent Historical Data

Cigarette smoking — quantitate by pack years
Cough and sputum production — qualitatively and quantitatively
Presence of obstructive lung disease — bronchitis, emphysema, asthma
Airways disease — cystic fibrosis and bronchiectasis
Recurrent pneumonias, particularly in the same lung region
Environmental/occupational exposure; current and past history
Prior surgery and its influence on the respiratory system
Old chest injuries
Current level of physical activities; often obtained from a friend or relative — quantitate by time and distance parameters

cyanosis, along with pursed lips breathing need little comment. When these signs are present, the respiratory system is markedly compromised. Since surgery stresses the patient's respiratory system, it is particularly appropriate that the physician pay careful attention to the level of physical activity and the degree of respiratory distress associated with a quantitative physical stress. By simply walking with the patient in the hall or up a flight of stairs, the physician can get a non-quantitative impression of the patient's exercise tolerance and hopefully guide the clinical assessment of the patient's respiratory reserve or indicate the necessity for further testing to clarify the lack of reserve.

From the standpoint of preventing postoperative complications, it is more effective to screen the majority of patients for respiratory abnormalities by simple tests than to study exhaustively a smaller number with clinically florid disease. Since the routine history and physical examination, although invaluable, is not always specific in providing the necessary data to assess the risk of postoperative complications, physicians have turned to additional diagnostic tests. The chest roentgenogram, arterial blood gas analysis, and standard pulmonary function testing have proved helpful in the preoperative evaluation of patients being considered for major surgery. Table 4* provides some relative spirometric and blood gas probability figures for risk of postoperative complications after major surgery.

Preoperative Respiratory Conditioning

Once an assessment of the preoperative respiratory status has been obtained, a program that can be understood and followed by the patient, nursing staff, and allied health professionals can substantially lower the postoperative respiratory complication rate. Whether the beneficial effects are due to the specific agents and maneuvers used or simply to the additional directed supervision the patient receives is an open question. Table 5* lists various factors included in a standard preoperative respiratory conditioning program.

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Table 4 — Risk of Postoperative Pulmonary Complications in Patients Undergoing Major Surgery

	Low	*Moderate*	*High*
Forced Vital Capacity (Liters)	1-1.5	0.6-1	<0.6
Forced Expiratory Volume in 1 sec. (L/sec)	0.5-1	0.3-0.5	<0.3
Maximal Mid Expiratory Flow (L/min)	100-200	50-100	<50
$PaCO_2$ torr	40-45	45-55	>55
PaO_2 torr	60-70	50-60	<50

Table 5 — Preoperative Respiratory Preparation

Cessation of Cigarette Smoking
Tracheobronchial Toilet
Bronchodilators
Clearing of Secretions
Respiratory Physiotherapy
Preoperative Antibiotics
Patient Education
Breathing Exercises
Oxygen Therapy

Cessation of cigarette smoking has long been advocated in preparing patients for major surgery. Cigarette smoking contributes to an increase in tracheobronchial secretions, reduced mucociliary clearance, and consequently promotes retention of secretions and airways obstruction. The cessation of cigarette smoking alone has not been effective in lowering the postoperative complication rate but should be the first step in a preoperative program.

Various medications and mechanical devices have been used preoperatively to relieve bronchospasm, enhance clearance of tracheobronchial secretions, and control infection. In general, respiratory treatment programs include the use of bronchodilators, inhalation of humidified gases with an ultrasonic nebulizer, segmental postural drainage, and chest physiotherapy.

The two classes of bronchodilators that are commonly used include the theophylline derivatives and the beta-adrenergic stimulators. Each class of medication has a number of newer formulations and preparations which have improved the efficacy of treating patients with airways obstruction.

Theophylline and its salt, aminophylline, are available in many preparations and can be given orally or intravenously. Rectal administration is discouraged because of erratic absorption which can lead to excessively high blood levels. For oral administration, the sustained release preparations are recommended to provide reliably constant blood levels. These medications may be given every 12 hours, with the usual dose in the range of 600-1200 mg per day. There is considerable variation among patients in the absorption and metabolism of theophylline and as a result, monitoring of serum

concentrations is recommended to achieve therapeutic levels (10-20μg/ml) and avoid side effects. Intravenous aminophylline is the most effective route of delivery, especially in the perioperative period. If the patient has not been taking theophylline, a loading dose of 4-6mg/kg of aminophylline is given over 15-30 minutes (not as a bolus); and this is followed by a constant infusion at 0.6mg/kg/hr, with frequent monitoring of blood levels. Notable exceptions to this rule are patients with liver dysfunction who do not metabolize the drug as well. Cigarette smokers and children tend to metabolize theophylline faster than the normal adult.

The beta-adrenergic class of bronchodilators can be given orally by aerosol or subcutaneously. Ephedrine and epinephrine are being superseded by isoproterenol, metaproterenol, isoetharine, terbutaline, and albuterol. If the patient is in acute distress, 0.5ml of 1 : 200 isoproterenol in 2ml normal saline or 0.5ml of isoetharine in 2ml normal saline may be given by an aerosol generator or by an intermittent positive pressure breathing machine. Isoetharine and metaproterenol have gained wide acceptance because of their decreased cardiac arrhythmia provoking potential. In less urgent situations such as a preoperative treatment program, aerosol therapy four times a day usually suffices. If the clinical situation warrants, the frequency of aerosolized bronchodilator administration can be as often as every 2 hours. Saline or sterile water alone, without a bronchodilator is not effective and should not be given.

Terbutaline is reputed to have the least cardiac-stimulating side effects of all the beta-adrenergic stimulators; however, skeletal muscle tremor is common with this agent in full therapeutic doses. Terbutaline is administered orally, 2.5 to 5.0mg or 0.25mg subcutaneously every 6 hours. In the past several months, a newer beta-adrenergic bronchodilator, albuterol, has received widespread attention because of the claim that it has the least of all stimulating effects. This medication can be administered every 6 hours orally or by a metered cannister aerosol preparation.

Corticosteroids have been used in some patients who do not respond to an aggressive bronchodilator program and in whom infection control has been accomplished. It should be understood that corticosteroids are not bronchodilators and are not recommended routinely in patients with chronic obstructive lung disease; however, in some patients with obstructive lung disease this medication may be necessary to help control bronchospasm. Patients presently on maintenance corticosteroids or those who have received corticosteroids within the year preceding surgery should be given the medication, since the stress of surgery may unmask relative adrenal insufficiency. Under these circumstances a parenteral corticosteroid such as hydrocortisone (100-200mg I.M.) is given several hours before surgery and again in the immediate postoperative period.

Tracheobronchial secretions should be minimized preoperatively. The most effective means of clearing secretions is the patient's own deep breathing and coughing maneuvers. The patient should be instructed in the optimum techniques preoperatively and hopefully can perform these maneuvers much more effectively after surgery. Tracheobronchial secretions tend to accumulate during sleep and are more voluminous and viscous upon awakening. In some instances, it is often necessary to carry out an aggressive tracheobronchial hygiene program 24 hours a day to allow for maximal clearance of retained secretions. In these patients, surgery should be scheduled for the latter part of the morning or early afternoon so that the patient can spend the morning clearing secretions accumulated overnight.

Respiratory physiotherapy is most effective if it is preceded by the inhalation of a bronchodilator. Physiotherapy is performed by a trained therapist and includes teaching the proper use of the diaphragm, exhalation through pursed lips, deep breathing and coughing, postural drainage with percussion and vibratory assisted exhalation.

The use of broad spectrum antiobiotics has been advocated in the management of chronic bronchitis for many years. In these patients, any evidence of clinical deterioration suggests tracheobronchial infection as the underlying cause. This is usually manifested by increased dyspnea, wheezing, change in cough, increase in sputum production, or change in sputum characteristics, i.e., increasing volume, darkening color, and a thickened consistency. The use of a broad spectrum antibiotic such as Tetracycline 250 mg four times a day or Ampicillin 500 mg four times a day is preferred, since the majority of organisms common to these patients are sensitive to these agents, and there is frequently a mixed flora rather than a single predominating organism. As is the case in the use of any antiobiotic, the choice should ultimately be directed by sound bacteriologic principles.

Patient education is mandatory in the treatment program of patients undergoing surgery. Respiratory maneuvers should be taught preoperatively so that effective therapy can start postoperatively. The patient's understanding and cooperation is essential if postoperative breathing exercises are to prevent or minimize respiratory complications. The patient should know why the maneuvers are necessary and should be taught appropriate deep breathing exercises and proper coughing. Familiarization with breathing exercises and with respiratory care equip-

ment should take place before surgery while patients are alert, pain-free, and unencumbered with restrictive dressings and tubes. This will reduce anxiety and improve cooperation after surgery. Observations and knowledge of the indices of preoperative pulmonary mechanics such as the vital capacity and the maximal inspiratory force should provide the patient with a postoperative goal. Preoperative instruction also motivates patients to participate actively in their recovery, improves morale, and may shorten the hospital stay.

Summary

The high incidence of postoperative respiratory complications has led to the necessity for a thorough evaluation. There is a need to identify risk factors, assess their significance, and design a perioperative treatment program to minimize complications during and after surgery. The nature of the preoperative evaluation depends on the type and extent of respiratory dysfunction and the surgical procedure planned. Objective parameters of lung function are not only helpful in the recognition of lung disease but also in establishing a baseline for comparison if complications arise during surgery and in the postoperative period.

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Pre- and Postoperative Respiratory Care — Is It Cost Effective?

Inflation in the cost of medical care has not responded to the economic recession and now is considered a major problem. Federal agencies and third-party payers such as the "Blues" are issuing flurries of guidelines designed to reduce medical costs. Particular attention has been drawn to respiratory therapy because technologic advances have resulted in large increases in the activity, personnel, and therefore the proportional cost of pulmonary medicine.

"Pre- and Postoperative Respiratory Care" as outlined in the paper by Dr. James Wellman in this issue of the *Journal* would seem to be one more instance of respiratory therapy vying for increasingly precious health care dollars. The laboratory evaluation and treatments recommended are not major items individually, but the cumulative expense for all patients at increased surgical or anesthetic risk could be substantial.

The cost effectiveness of respiratory care in these patients is a matter of decreasing postoperative morbidity and the enormous costs of increased hospital, particularly ICU, days. Most third-party groups, including federal programs and private insurors, agree that the key to major cost control in medical care is primarily in decreasing hospital days rather than in eliminating treatments or expensive technology.

A 1970 study[1] randomly divided surgical patients and gave one group a presurgical evaluation and respiratory therapy as indicated. The patients who were determined to be at increased risk demonstrated an impressive decrease in morbidity and mortality with respiratory care. The complication rate dropped from 60 to 22 percent, and there was a substantial reduction in the severity of complications in the treated group. Four of the untreated patients died versus no deaths in the treated group. Certainly, such a major drop in morbidity would result in many fewer postoperative inpatient days.

These studies demonstrate that properly selected and administered respiratory evaluation and care can be cost-effective and help meet another even more important goal: *better patient care.*

William R. Kenny, M.D.
Atlanta

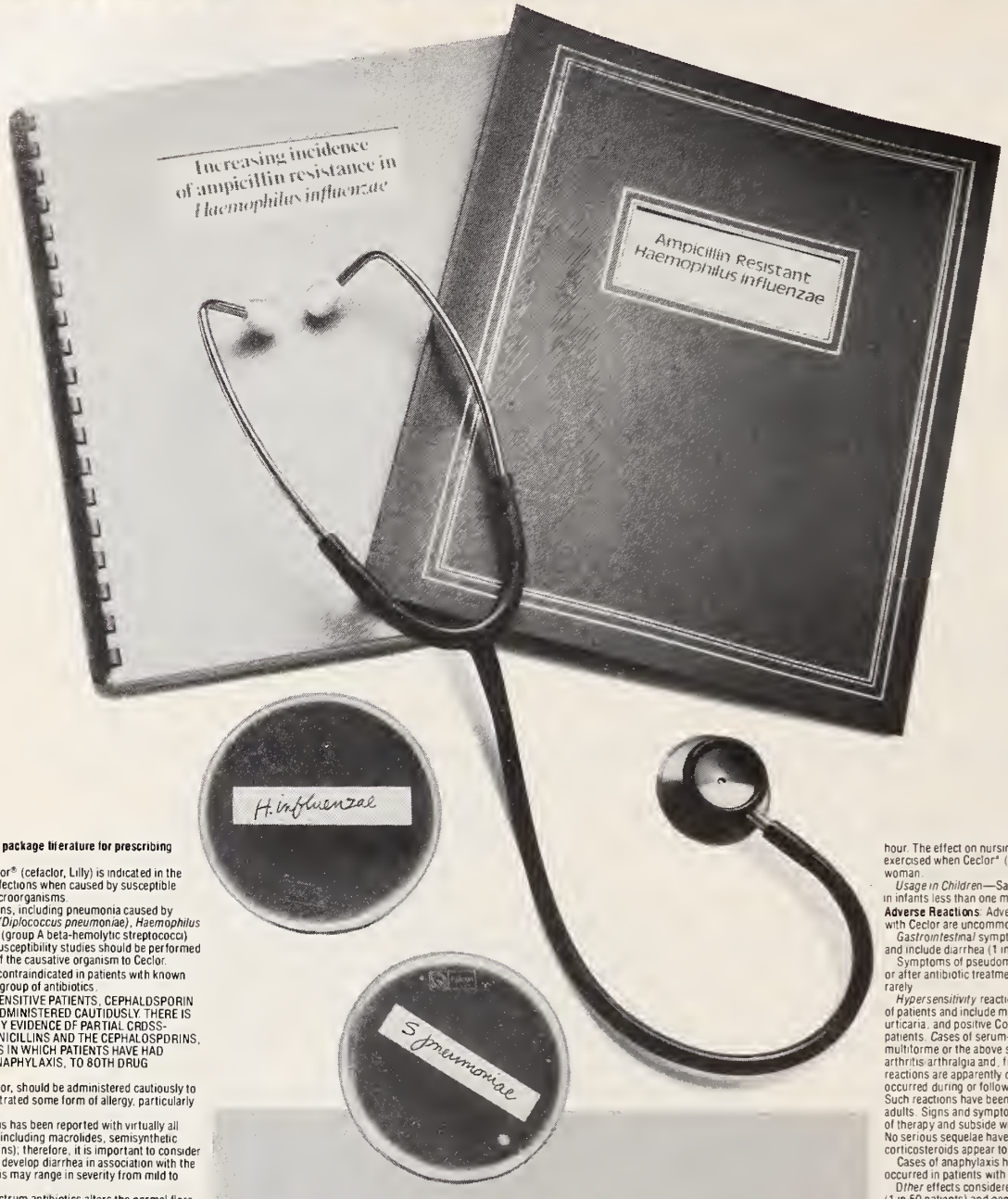
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(Editor's Note: "Pre- and Postoperative Respiratory Care" is part of a series of articles sponsored by the Georgia Thoracic Society and written for the Journal *by members of the GTS.)*

The views expressed on the Editorial Page are not necessarily those of the MAG unless so stated.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALDSPORIN ANTIBIDTICS SHDULD BE ADMINISTERED CAUTIDUSLY. THERE IS CLINICAL AND LABDRATDRY EVIDENCE DF PARTIAL CRDSS-ALLERGENICITY DF THE PENICILLINS AND THE CEPHALOSPDRINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIDNS, INCLUDING ANAPHYLAXIS, TO BDTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Dther causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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The Great "Informed Consent" Debate: Should the Disclosure of Risks and Alternatives by Physicians Be Standard Pre-Operating Procedure?

ROBERT N. BERG, *Atlanta**

THE RECENTLY ENDED 1983 session of the Georgia General Assembly was marked by the introduction of proposed bills covering a wide variety of health care-related topics, ranging from certificates of need and chiropractors to "living wills" and hospital billing procedures. One of the bills introduced in the 1983 session stirred up a good deal of controversy and debate, and, if enacted, would have had a major impact upon many physicians: House Bill 49, related to "informed consent."

As originally introduced, House Bill 49 was designed to deal with one particular situation — the need for breast cancer patients to be informed, prior to undergoing breast cancer treatments, of the risks involved in the proposed treatment, together with the alternatives to that treatment available to the patient. By the time House Bill 49 passed the House of Representatives and was submitted to the Senate Human Resources Committee for consideration, however, the bill had been converted (by Committee substitute) to one of general applicability, setting out the disclosure requirements which physicians must follow prior to undertaking any surgical procedure. As a result, the debate in the Georgia Senate over House Bill 49, rather than dealing with the narrow question of what constitutes informed consent in the context of one particular type of surgical procedure, evolved into a discussion of a much broader question: What information should a physician be required to give to a patient prior to engaging in any type of surgical treatment?

House Bill 49 ultimately was not passed by the Georgia Senate; rather, the Senate Human Resources Committee agreed to hold the bill over the summer and possibly reconsider it during the 1984 legislative session. Nonetheless, since the "Great Informed Consent Debate" in all likelihood merely has been adjourned, rather than concluded, this month's Legal Page takes a look at the present state of the law in Georgia relating to "informed consent" and previews some of the major "informed consent" issues likely to be discussed during the 1984 legislative session.

The Status of Informed Consent in Georgia

Historically, the doctrine of "informed consent" has been a creature of common law, rather than statute. Thus, in most states, courts have established the nature of

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the ''consent'' which a physician must obtain before treating or operating on a patient. In most cases, the duty so imposed on physicians is to disclose to the patient the nature of the risks involved in the proposed treatment or operation. The failure on the part of the physician to obtain this ''informed consent'' may lead to the imposition of liability on the physician for negligence.[1]

In Georgia, however, the common law doctrine of ''informed consent'' has been specifically rejected. Rather, the duty to disclose placed upon Georgia physicians arises out of the ''Georgia Medical Consent Law,'' enacted by the Georgia General Assembly in 1971.[2] Pursuant to this statute, as construed over the years by Georgia courts, a physician is not under any duty to disclose the risks of treatment to a patient. Quite the contrary, the physician need only disclose ''in general terms the treatment or course of treatment'' in connection with which the consent of the patient is obtained.[3]

Thus, the Georgia Medical Consent Law, interpreted by the courts as defining the extent of the duty imposed upon physicians to disclose information to patients prior to undertaking a surgical procedure, has served as an insurmountable barrier to patients instituting lawsuits on the basis of contentions that physicians, by failing to disclose the possible risks involved in the surgical procedures, failed to obtain ''informed consent.'' For example: a physician was found not to be liable for failing to disclose the risks involved in a tonsillectomy and adenoidectomy, since the physician had informed the patient of the general terms of treatment.[4] A physician who had disclosed the general course of treatment was found not to be liable for failing to disclose the possibility of permanent scarring inherent in the performance of a face-lift operation.[5] A physician was found not to be liable for failing to disclose the risk of hepatitis associated with blood transfusions, because the patient was aware of the general course of treatment to be undertaken.[6] And so on and so on.

As a result, patients and their attorneys realized that, if physicians were to be held liable for the failure to disclose the risks involved in surgical procedures, the Georgia Medical Consent Law must be amended to enunciate this disclosure requirement. While the need to amend that statute was obvious, however, the more difficult question was how far should the amendment go. Should a physician be required to disclose both the risks involved in and the available alternatives to a surgical procedure, or simply to disclose the risks involved? Should the physician be required to disclose *all* risks, or just risks that are material or significant? Should the disclosure requirements be based upon what the physician believes he or she should disclose, or on the basis of what the patient believes he or she should know in order to make an informed decision? Should the physician's duty be an objective one, based upon what the medical profession generally would view as the normal informational needs of a normal patient, or should it be a subjective one, based upon what the physician actually knows about the particular patient?

As one might expect, the existence of questions such as these suggest the availability of a wide variety of alternatives in imposing disclosure requirements upon physicians. Many of these alternatives were considered by the 1983 General Assembly, and it is expected that they will resurface in 1984.

Issues Likely to Arise in the 1984 Consideration of an ''Informed Consent'' Bill

''Risks'' Versus ''Alternatives.'' One of the major topics of debate in considering an amendment to the Georgia Medical Consent Law should be the question of whether the disclosure requirements imposed upon physicians should entail the disclosure both of the risks involved in the particular surgical procedure or treatment *and* the availability of alternatives to that treatment. Proponents of such a dual requirement suggest that a patient, in order to be truly ''informed,'' must be made aware of the fact that alternative treatments or procedures may be available. As one example, proponents would argue that a patient with breast cancer deciding whether or not to undergo a mastectomy, in addition to being informed as to the

potential risks and side effects involved, should also be informed as to the availability of more conservative or, possibly, non-surgical alternatives.

On the other hand, the imposition of a requirement making it mandatory for physicians to disclose all available alternatives prior to undertaking a surgical procedure or treatment would move Georgia from one end of the legislative spectrum to the other: while a majority of states require the disclosure of risks, few if any states go further and require the disclosure of alternatives. The General Assembly thus would be replacing a statute containing a very limited disclosure requirement with one containing a very broad requirement.

Moreover, Georgia presently has a special statute dealing with sterilization procedures,[7] which, among other things, provides that a physician may not perform a sterilization procedure unless the patient has requested the procedure in writing following "a full and reasonable medical explanation . . . as to the meaning and consequence of such operation."[8] This provision, which effectively sets forth the "informed consent" standard in sterilization procedure cases,[9] does not include a requirement that the alternatives to sterilization be disclosed by the physician. It may be difficult to justify a suggestion that the Georgia General Assembly, which chose to impose greater disclosure requirements upon physicians in sterilization procedure cases than in other cases — but not so great as to include the disclosure of alternatives — amend the general "informed consent" statute to impose even greater disclosure requirements upon physicians *in all cases* involving surgical procedures or treatments.

"All" Risks Versus "Material" Risks. A second, related question which in all likelihood will be debated during the 1984 legislative session is whether or not a physician should be required to disclose *all* risks involved in a surgical procedure or treatment, or something less than all risks. In general, there appears to be agreement that it would be virtually impossible for a physician to comply with a requirement that he or she disclose *all* risks.

At the same time, however, there may be considerable debate over the exact extent to which the physician's disclosure obligation should be qualified. For example, if a physician is required to disclose only "material" or "significant" risks, do those risks have to be known by the physician (or by the profession generally) at the time the surgical procedure is to be undertaken? Also, there is the question of "material to whom?" A risk may be material to the physician, but, at the same time, may not be material to a patient. The reverse may also be true; a risk may be material to a patient, perhaps even to the extent of being determinative as to whether or not to have the procedure performed, but may not be viewed as material by the physician.

Finally, there is the question of the definition of "material." Is a "material" risk the same as a "substantial" or "significant" risk? Will the materiality of a risk depend upon the nature of the surgical procedure, or on the probability or likelihood that it will occur, or both?

"Objective" Physician Versus "Subjective" Patient. A third likely topic of debate with respect to any "informed consent" bill will be the question of the standard by which the disclosure requirements will be measured. Presently, in Georgia, physicians are held to be an "objective" standard in malpractice cases — a physician will be found to have malpracticed only if he or she fails to use that degree of care and skill ordinarily used by the medical profession generally under similar conditions and like surrounding circumstances. A similar standard in an "informed consent" statute would focus on an "objective" physician. That is, the physician's duty to disclose would be determined by looking at the question of "what would the medical profession generally consider ordinarily to be a 'material' risk under similar conditions and like surrounding circumstances?"

On the other hand, some may argue that the appropriate standard should be one that focuses on the disclosure needs of the "subjective" patient. Under this standard, the physician would be required to view disclosure through the eyes of the patient, rather than through the eyes of the medical profession generally; a physi-

cian would be required to disclose those risks which the physician (or perhaps the medical profession generally) knew or should have known would be viewed as material by the particular patient involved.

In addition to these issues, a number of other issues may also arise, such as: must the disclosure be made by the physician, or should the test be whether or not the patient, by whatever source or sources, was made aware of the risks involved in a surgical procedure? Must a consent in writing be obtained, or can the physician satisfy the disclosure requirements through oral disclosure? Will the disclosure requirement be imposed in all cases, or will a physician be authorized to act without obtaining disclosure in emergency situations or in situations involving mentally incompetent patients?

In all likelihood, the Georgia General Assembly, in the 1984 legislative session, will consider, and perhaps provide the answers to, these questions.

Notes

1. See, generally, Berg RN. Informed consent in Georgia: previewing the "1980 Model." JMAG (January, 1980), and articles cited at note 1 therein.
2. O.C.G.A. §§31-9-1 *et seq.*
3. O.C.G.A. §31-9-6(d). See, e.g., *Young v. Yarn,* 136 Ga. App. 737 (1975); *Parr v. Palmyra Park Hospital, Inc.,* 139 Ga. App. 457 (1976); *Holbrook v. Schatten,* ____ Ga. App. ____ (January 6, 1983).
4. *Fox v. Cohen,* 160 Ga. App. 270 (1981).
5. *Young v. Yarn, supra.*
6. *Parr v. Palmyra Park Hospital, Inc., supra.*
7. O.C.G.A. §§31-20-1 *et seq.*
8. O.C.G.A. §31-20-2.
9. The Georgia Medical Consent Law expressly exempts sterilization procedures from the provisions of that Law. O.C.G.A. §31-9-5.

Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

Award winning in its architectural design, Ridgeview is housed on 40 acres of land with lighted tennis and volleyball courts, swimming pool, and a fully equipped gymnasium for supervised sports and physical education programs.

Adult Chemical Dependency

The Adult Chemical Dependency Program offers a unique and innovative treatment modality that includes inpatient treatment and an emphasis on aftercare. The staff views alcohol and drug dependency as a primary disease that affects a person physically and psychologically.

The seven element program includes medical, educational, and family therapy, Alcoholics Anonymous and Narcotics Anonymous, group psychotherapy, non-chemical coping skills and spiritual counseling.

Adult Psychiatric Treatment

The Adult Psychiatric Program at Ridgeview provides specialized treatment for persons suffering from depression, anxiety, schizophrenia, manic-depressive disorders, personality disorders, and other similar dysfunctions.

Under the psychiatrist's leadership, treatment is specifically designed for each patient's particular needs in order to promote a productive return to family, job, and community as early as possible.

Adolescent Treatment Services

The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

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measures up... at a reasonable cost!

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Rufen® offers your patient effective relief, both as first therapy or after other potent medications fail. In comparable trials with indomethacin[1,2] sulindac,[3,4] and other antiarthritic agents,[5-7] findings consistently demonstrate high improvement with ibuprofen (Rufen) by such objective and subjective measures as reduction of swelling, improved grip strength,[1] reduced morning stiffness,[1] better ambulation,[1] improved range of motion,[4] reduction and relief of pain.[1-5]



Low Score in Side-Effect Risk

Through more than 13 years of worldwide use, ibuprofen continues to demonstrate exceptional gastrointestinal tolerance vis-a-vis aspirin and other antiarthritic agents. In a recent series of double-blind trials of ibuprofen, naproxen and other NSAID's, only placebo was shown to produce less G.I. lesions than ibuprofen on gastroscopic examination.[5]

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See next page for brief summary of prescribing information.

Measure RUFEN® (ibuprofen) for GI Tolerance

Even in arthritic patients with a history of GI disease



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Over a five-year period, ibuprofen was administered to 64 patients with known peptic ulceration and 42 with known gastric intolerance to other antiarthritis drugs.

Twenty-six patients remained in treatment, 23 left treatment following remission, and 35 dropped out for reasons unrelated to side effects. In this specially selected group of GI-intolerant patients, only 13 (12.3%) discontinued ibuprofen because of GI intolerance.

"Any drug used in the control of the symptoms of the chronic arthritis must be tolerated for long periods without undue gastric discomfort...From this study it appears that ibuprofen is eminently suitable."[8]

Peptic ulceration and GI bleeding, sometimes severe, have been reported. Rufen® should be given under close supervision to patients with a history of upper GI tract disease.

References: 1. Royer GL, Jr, Moxley TE, Hearron MS, et al: *J Int Med Res* 3:158-171, 1975. 2. Royer, GL, Jr, Moxley TE, Hearron MS, et al: *Curr Therap Res* 17:234-248, 1975. 3. Brackertz B, Busson M: *Brit J Clin Pract* 32:77-80, 1978. 4. Tausch J, Fasching U: *Brit J Clin Pract: A symposium supplement, IXTH European Congress of Rheumatology*. Wiesbaden, Germany, Sept 2-8, 1979, pp 53-61. 5. Lanza FL, Royer GL, Jr, Nelson RS et al: *Dig Dis & Sci* 24:823-828, 1979. 6. Pavelka K, Susta A, Vojtisek A et al: *Rheumatol and Rehab* 12:68-73, 1973. 7. Tretenhahn W: *Brit J Clin Pract: A symposium supplement, IXTH European Congress of Rheumatology*, Wiesbaden, Germany, Sept 2-8, 1979, pp 45-52. 8. Cardoe N: Curr Med Res & Opinion 3:518-520, 1975.

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RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. *Special Senses:* hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photoallergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. *Do not exceed 2,400 mg per day.*

CAUTION: Federal law prohibits dispensing without prescription.

To Extend Our "Reach To Recovery"

LAMAR S. McGINNIS, M.D., F.A.C.S., *Decatur**

THE SCOURGE OF BREAST CANCER has been with us since earliest recorded medical history. In the 1890s, Dr. William Halsted, while at Johns Hopkins, developed a surgical operation which, with some variations, remained the standard treatment for breast cancer well through the first half of the twentieth century. The psychologic trauma of this surface-mutilating surgery was always apparent, and some observers questioned whether fear of the operation caused some patients to delay consultation until their cancer was in an advanced stage.

In 1952, Teresa Lasser realized from her own mastectomy experience that help and support were needed. She subsequently initiated the Reach To Recovery program. In 1969, the American Cancer Society merged its rehabilitation program with Reach To Recovery. This American Cancer Society Reach To Recovery program has become the most widely consulted cancer rehabilitation program in the world. It has become the model for patient support.

In the 1960s, more and more questions were asked regarding the radical mastectomy and its success in treating breast cancer. In 1967, D. H. Patey reported in the *British Journal of Cancer* his success with a lesser operation, subsequently called the "modified radical mastectomy." Initial slow but steady acceptance of this less mutilating procedure has been noted. In a 1979 consensus conference sponsored by the National Institutes of Health, total mastectomy with axillary dissection (i.e., modified radical mastectomy) was recommended as the standard treatment for breast cancer, while other methods of treatment are being studied. In 1982, the American College of Surgeons Commission on Cancer carried out long and short-term surveys regarding patterns of care for female breast cancer. A total of 756 hospitals with approved cancer programs reported on 27,442 patients in the long-term survey and 19,981 patients in the short-term. Much was learned, but of greatest interest was the fact that presently only 3.4% of breast cancer patients are being treated by radical mastectomy.

Much controversy continues regarding the degree of surgery to be performed, the place of radiation therapy, the appropriate use of chemotherapy, etc. Studies are in place which in time may yield some more definitive answers.

Beginning in the 1960s, surgical procedures for breast reconstruction after mastectomy were developed. Crude at first, but progressing steadily through the 1970s, much of the definitive work was done in Atlanta. Today, many alternatives are available for breast reconstruction with very good cosmetic results.

The American Cancer Society's Reach To Recovery program has been the leader in assisting patients toward a full physical and psychologic recovery after the

* Dr. McGinnis practices general surgery and is Chairman, Executive Commitee, Georgia Division, American Cancer Society. Send reprint requests to him at 365 Winn Way, Ste. 201, Decatur, GA 30033.

Prepared at the request of the Georgia Division, American Cancer Society.

trauma of a mastectomy. The Cancer Society recognized early the importance of reconstructive surgery and realized that a logical extension of the Reach To Recovery program would be to further assist those patients wanting information about such surgery. A carefully worded statement regarding breast reconstruction was developed and is a part of the routine Reach To Recovery literature. If the patient is interested, she is directed to talk with her surgeon for further information. Printed information regarding breast reconstruction is available from the Cancer Society, and plans are underway to provide specific training for Reach To Recovery volunteers who have had breast reconstruction to visit patients desiring such, on the recommendation and approval of their surgeon.

Our goal with this new program is to try to fill the need for more information about post-mastectomy breast reconstruction for interested patients and to generate more public information regarding the availability of this procedure. Earlier detection of breast cancer may be a fringe benefit in that some patients, fearing the loss of a breast, may seek earlier consultation if they know more about the possibility of breast reconstruction.



heart page
heart page
heart page

Bedside Hemodynamic Monitoring

MILTIADIS A. STEFADOUROS, M.D., *Augusta**

THE REMARKABLE REDUCTION in hospital mortality among patients treated in a coronary care unit for acute myocardial infarction (MI) has been the result of prompt recognition, aggressive treatment, and effective prevention of life-threatening arrhythmias. Any further reduction in mortality is predicated on early detection and successful management of the currently most common cause of death in these patients, i.e. "pump failure."[1] This is a state where the heart, suddenly deprived of the function of its infarcted wall, either is unable — because of myocardial dysfunction, hypovolemia, or both — to maintain a cardiac output adequate to meet the metabolic needs of the body, or can accomplish this task only at the cost of prohibitively high levels of filling pressure.

Several clinical signs permit recognition of these two forms of pump failure. Thus, inadequate cardiac output is manifested by tachycardia, weak arterial pulsations, oliguria, hypotension, cold extremities, diaphoresis, altered mental state, and shock. Severe elevation in left ventricular (LV) filling pressure is manifested by dyspnea, orthopnea, gallop sounds, and moist rales suggesting lung congestion or pulmonary edema. Furthermore, involvement of the right ventricle leads to jugular venous and hepatic distention, with or without large systolic "V" waves of functional tricuspid regurgitation, and formation of edema or effusions.

Early recognition of the presence, nature, and severity of pump failure is of prime therapeutic and prognostic importance. Thus, the mortality of hospital patients after acute MI has been found to be 6% if no clinical signs of heart failure were present (Killip class I); 17% if mild to moderate heart failure was detected (class II); 38% if severe heart failure was present, manifested by pulmonary edema (class III); and 81% in patients with cardiogenic shock (class IV).[2] Such clinical evaluation requires no special instruments and entails no cost, inconvenience, or harm to the patient. These advantages, however, are frequently overshadowed by certain limitations. For example, a good amount of clinical expertise is needed for the detection of subtle physical signs of mild pump failure. Certain physical signs may incorrectly be attributed to heart failure when in fact they are the result of unrelated coexisting diseases. The clinical data are of qualitative or semiquantitative nature, hence not amenable to precise measurement. Clinical manifestations of rapid hemodynamic changes may appear after considerable delay which prevents timely recognition and early treatment of the initial event. Similar clinical pictures may be caused by different hemodynamic disturbances requiring different treatments. Sphygmomanometric determination of blood pressure may be unreliable in patients with shock.

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Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

For critically ill patients, these limitations amply justify use of invasive hemodynamic monitoring by means of a flow-directed, balloon-tipped Swan-Ganz catheter, which can be percutaneously inserted at the bedside into the antecubital, subclavian, internal jugular, or femoral vein and advanced, with or without fluoroscopic guidance, into the right atrium, right ventricle, and the pulmonary artery.[3] Through the lumen ending at the end-hole of the catheter tip, pulsatile and mean pressures from these chambers are monitored, and blood samples for oximetric analysis can be obtained if necessary. With the catheter tip into a large or medium pulmonary arterial branch, the balloon can be momentarily inflated with a small amount of air or carbon dioxide, to occlude the arterial lumen and permit recording of the pressure distal to the occlusion. Because this pressure is practically equal to that obtained by advancing the catheter — with the balloon deflated — into the "wedge" position, it is termed pulmonary wedge pressure (PWP). It is (within a few mm Hg) equal to the mean left atrial pressure and, in the absence of mitral valve disease or other conditions obstructing flow from the pulmonary veins to the left atrium and left ventricle (pulmonary vein stenosis, cor triatriatum, left atrial masses, etc.), faithfully reflects the pre-a, end-diastolic or filling pressure of the left ventricle (LVEDP), an indirect measure of LV *preload*. If the catheter tip is positioned appropriately, it is possible to alternately record the PWP or the pulmonary arterial pressure by, respectively, inflating or deflating the balloon, without having to manipulate the catheter. This is important because, unless the pulmonary vascular disease or pulmonary arterial vasoconstriction is present, the pulmonary arterial end-diastolic pressure (PAEDP) is practically equal to PWP. Thus, once the correspondence between PAEDP and PWP is established, subsequent balloon inflations are unnecessary since variations in PAEDP are taken to represent equivalent changes in PWP and, by inference, LVEDP.

Using a modern (triple-lumen) version of the initial Swan-Ganz catheter, cardiac output and index (CI) can be computed by manual or automated analysis of thermodilution curves obtained by injecting a small amount of cold saline or 5% dextrose solution into the lumen leading to a proximal side-hole located 25-30 cm from the catheter tip, and recording the transient fall in temperature sensed distally by a small thermistor unit located about 5 cm from the catheter tip within the pulmonary artery. With the catheter in its usual position, the injection site is close to the junction of the vena cava and the right atrium, sufficiently upstream to permit adequate mixing of the injectate with blood.

The arterial pressure can be monitored by a plastic indwelling catheter inserted percutaneously into the radial, brachial, or femoral artery, and used as a measure of LV *afterload*, defined as the force per unit cross sectional area (wall stress) that opposes muscle shortening. In the intact left ventricle, wall stress is related directly with its pressure and radius and inversely with its wall thickness (Laplace's Law). Because acute interval changes in LV radius and wall thickness are of small magnitude, the chief determinant of wall stress is LV pressure. Since at the very onset of ejection this pressure is equal to the diastolic arterial pressure, the latter is accepted as a convenient measure of afterload. In addition, systemic vascular resistance reflecting the state of arteriolar vasoconstriction can be computed as the ratio of mean arterial pressure and thermodilution cardiac output. And the product of stroke volume index (CI/heart rate) and mean systolic arterial pressure provides the stroke work index (SWI). Plots of SWI against simultaneous values of PAEDP during spontaneous or induced variations of the latter, represent in fact modified function (Starling) curves, whose position and slope reflect *contractility*.

With the use of a Swan-Ganz and an arterial catheter, derangements in LV performance as a pump can be defined in terms of abnormalities in one or more of its determinants, i.e., preload, afterload, contractility, and heart rate, providing guidance for specific treatment directed at the causative factor(s). For example, preload can be reduced by diuretics or nitrates and increased by blood volume expansion with Dextran infusion. Afterload can be decreased by intravenous administration of vasodilators such as nitroprusside or nitroglycerin, and increased

by vasopressor amines such as angiotensin or dopamine. Contractility can be augmented by digitalis and a host of beta-adrenergic agents (e.g., isoproterenol, dobutamine, epinephrine), and decreased by beta-adrenergic blocking agents (e.g., propranolol), or by calcium antagonists. Heart rate can be increased by atropine, beta-adrenergic drugs, or pacing and decreased by digitalis, propranolol, or specific pharmacologic or electrical treatment of tachyarrhythmias. It is important to remember that the benefit accrued by the effect of some of these agents on either preload, afterload, contractility, or heart rate may be offset by its simultaneous untoward effect on the other three determinants of LV function. Thus, digitalis or beta-agonists improve contractility but at the same time they increase myocardial oxygen demand, thereby jeopardizing myocardium in critically perfused areas; propranolol has exactly the opposite effect. Diuretics or nitrates decrease preload and relieve pulmonary congestion but may drastically reduce cardiac output and threaten blood pressure; the opposite is true with dextran infusion. It is obvious that thorough knowledge of, and familiarity with, all actions of each of these drugs are prerequisite to their safe use.

Early recognition of the presence, nature, and severity of pump failure is of prime therapeutic and prognostic importance.

In addition to assisting therapeutic decisions, hemodynamic data have proven to be of considerable prognostic importance. For example, the mortality in hospital patients after acute MI was found to be 6% to 7% if the CI on admission exceeded 2.5 L/min/m^2, regardless of the value of PAEDP. For those with a lower CI, the mortality was 29% if PAEDP was less than 18 mmHg and 36% if PAEDP was 18 mmHg or more.[4] Similarly, in hospital patients with cardiogenic shock after acute MI, the mortality was 100% if PAEDP exceeded 29 mmHg regardless of the value of CI. For those with a CI exceeding a 2.0 L/min/m^2, the mortality was 92% if the PAEDP was above 15 mmHg and 63% if PAEDP was 15 mmHg or less. The lowest mortality (13%) was observed in those with PAEDP of less than 29 mmHg and a CI in excess of 2.0 L/Min/m^2.[5] Similar escalation of mortality in hospital patients has been observed in hemodynamic subsets of patients with acute myocardial infarction, stratified on the basis of initial cardiac index and PWP into four distinct clinical subsets as follows: (1) no pulmonary congestion or peripheral hypoperfusion, (2) isolated pulmonary congestion, (3) isolated peripheral hypoperfusion, and (4) both pulmonary congestion and hypoperfusion. The mortality in hospital corresponding to these four subsets was 2.2%, 10.1%, 22.4%, and 55.5%, respectively.[6]

There is no unanimity of opinion regarding the indications for invasive hemodynamic monitoring. In certain specialized research units, hemodynamic monitoring for prognostic evaluation or for assessment of new forms of treatment in patients with uncomplicated acute MI is conducted according to approved protocols. Hemodynamic studies for purposes of management are indicated for initial evaluation and subsequent monitoring of left and right ventricular function; for monitoring of the effects of vasoactive or inotropic agents; and for detecting and treating complications such as congestive heart failure, hypotension, shock, unstable post-MI angina, cardiac tamponade, and rupture of a papillary muscle or the interventricular septum. The added morbidity and mortality stemming from delayed detection or "blind" treatment of these complications without the benefit of objective hemodynamic data far outweigh the potential risk of complications from use of a Swan-Ganz catheter, which include transient arrhythmias or catheter knotting during its passage through the right heart chambers, balloon rupture, pulmonary artery rupture, pulmonary infarction, venous thrombosis, and infection.[7] The incidence of these complications is rather low if the operator adheres to established guidelines.

In conclusion, invasive bedside hemodynamic monitoring represents a valuable,

reliable, and reasonably safe procedure. Its judicious use leads to more accurate prognosis, more secure and objective diagnosis, and, hence, better survival in critically ill patients, particularly those with complicated acute myocardial infarction.

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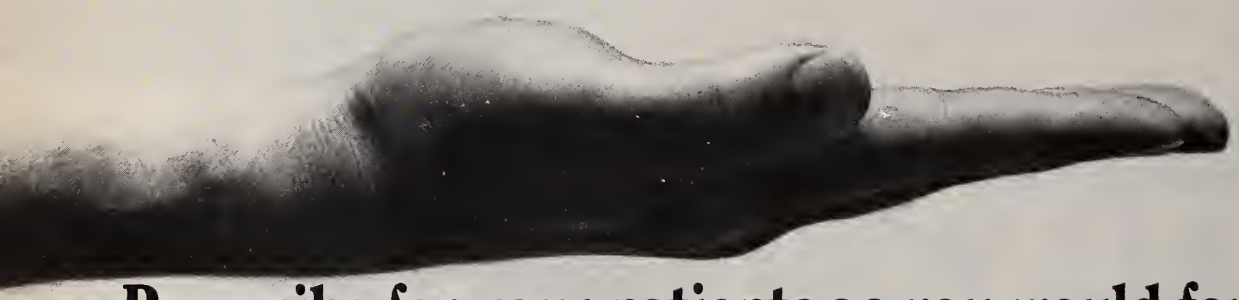
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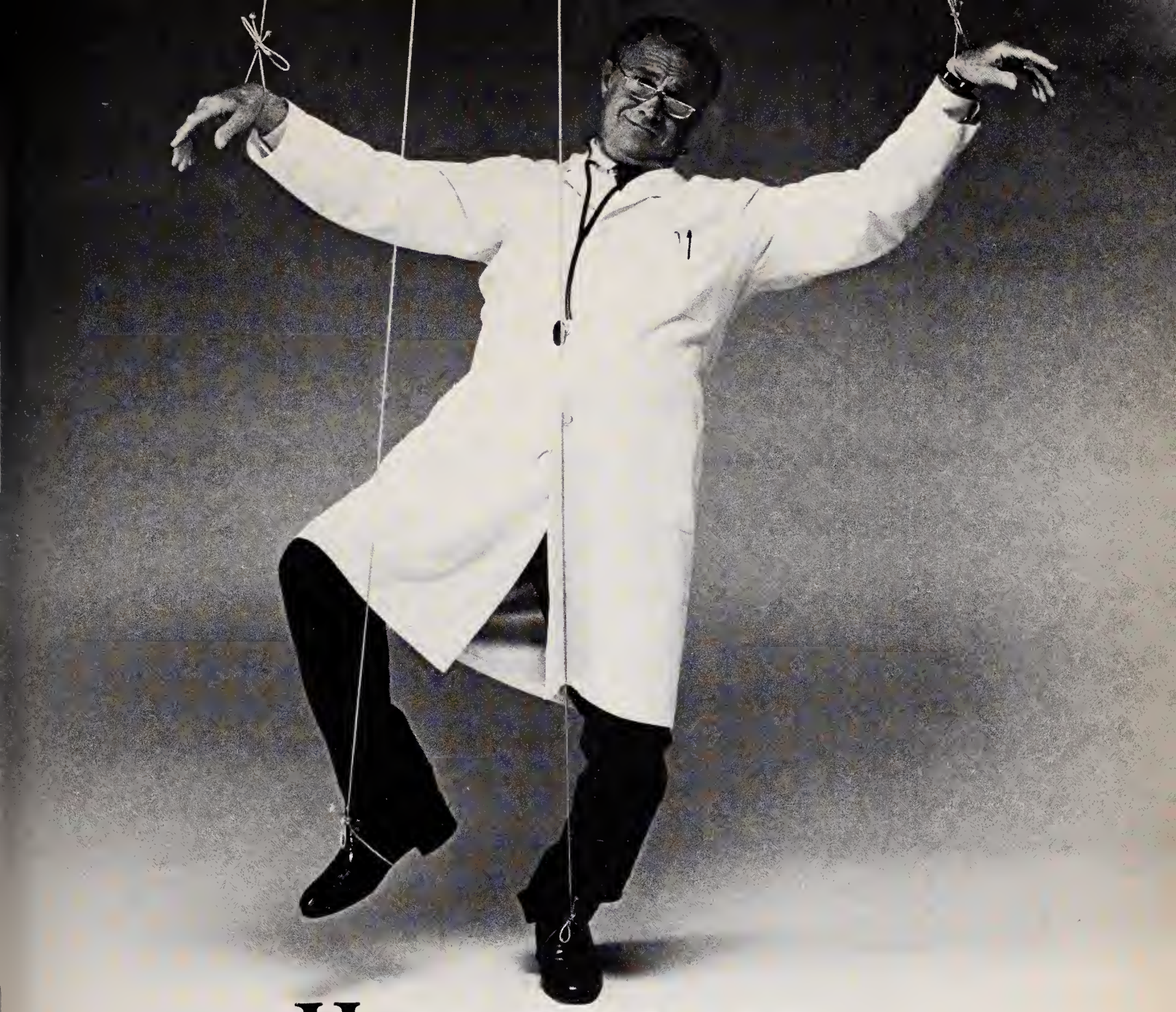
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president's letter



MAG 1982-1983 — A Summing Up

A YEAR IS A SHORT TIME during a period of rapid change. This has been an eventful year, and, I hope, a progressive year for MAG. It has been a challenging year for me.

There was much that we proposed to do:

1. Intensify our public relations activities, especially in the area of public education, with the cooperation of the medical school faculties and the resources of the Auxiliary;

2. Develop a statewide organization of hospital medical staff officers with which could be addressed the unique and increasing problems faced by hospitals, subsequently integrating this group into the MAG organization;

3. Work aggressively with the business community in forming business-medicine coalitions in many localities around the state, designed to identify reasonable ways of cost containment — MAG would serve as a clearinghouse of information about these activities;

4. Form a Council of Medical School Deans to provide a forum for discussion of problems of mutual interest and concern to MAG and the medical schools and to establish a pattern of regular participation by the deans in MAG deliberations at all levels;

5. Bring together at a statewide conference all of the diverse leadership groups working at the business of MAG in order to bring progress reports about things in process, to give an overview of the problems to be faced, and to discuss projects which need to be planned;

6. Gather all committee chairmen at a joint meeting in order to update and clarify charges to the committees, give reports on activities assigned to the various committees, identify overlaping responsibilities, and develop a regular committee reporting system to the Executive Committee and through the MAG *Journal;*

7. Review the purpose of the MAG *Journal,* emphasizing its importance as a reporting organ of the MAG and an official source for release to the public media of major MAG policy matters and information about significant projects;

8. Expand the involvement of the Auxiliary in primary organizational activities by adding Auxiliary members to committees, delegating to them very important segments of the public education efforts, and charging them with a major role in recruitment of new members for MAG;

9. Push through to the final stage the development of MAG Mutual, making it a fully operational professional liability insurance company as soon as possible.

Much has been accomplished with the dedicated and enthusiastic support of our excellent staff and with the hard work and cooperation of the officers and board of MAG. Expanded PR plans are in process, hospital medical staff officers have been organized, business-medicine coalitions are becoming active, a Council of Deans has been formed and is meeting, a statewide leadership conference has been held successfully, committee chairmen have been brought together for interchange of ideas, a Committee on Committees has been appointed to restructure the committee system, the *Journal* has become more of a voice of the MAG organization, Auxiliary members have been appointed to committees and are providing significant input, and MAG Mutual is very much in business and has had a surprisingly successful first 9 months of operation.

It has been a good year for MAG and has been a good year for me personally. It is hard to say good bye, but the nostalgia of the time will be tempered by the fact that I will not be parting ways with those with whom I have worked so pleasantly during this past year. I will still be around, interested and wanting to participate in any way that I can be helpful.

Charles D. Hollis, Jr., M.D.

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PERSONALS

First District

A $100,000 endowment fund for nursing studies in rural Georgia has been established in the name of **Curtis G. Hames, M.D.,** of Claxton. Nursing programs from the 43-county east Georgia region will now be eligible to offer scholarships in Dr. Hames' name. Dr. Hames' research has linked geographic factors shared by coastal Georgia and regions of Finland and China with the higher-than-average cardiovascular disease rates their populations have in common. He sits on the faculty of the Medical College of Georgia where a $250,000 Chair of Family Medicine has been endowed in his name. Among his list of honors are the international Albert Lasker Special Public Health Award for 1980 and the Governor Hardman Award from the MAG. The American Medical Association has devoted entire issues of its *Archives of Internal Medicine* and *Journal of Chronic Diseases* to Dr. Hames' studies. He has published more than 100 articles in major medical journals on subjects ranging from pesticide pollution to psychological determinants in disease.

Third District

Virgle W. McEver, Jr., M.D., of Warner Robins, was inducted into the Medical College of Georgia Founder's Club recently in Augusta.

Fifth District

John G. Leonardy, M.D., of Atlanta was named president-elect of the American College of Allergists at its 39th Annual Congress held recently in New Orleans.

On Feb. 18, 1983, the government of the Republic of Haiti recognized 30 years of service to the people of that Caribbean country by **James Funk, M.D.** At an impressive ceremony in Port-au-Prince, Dr. Funk was awarded the title of Commander in the National Order of Honor and Merit.

The presentation was made by Dr. Muller Garnier, Undersecretary of State on behalf of the President of the Republic. The recognition ceremony was attended by many of Dr. Funk's Haitian friends as well as government dignitaries.

In presenting the decoration, Dr. Garnier recognized the Haitian-American brotherhood and affection that have characterized Dr. Funk's annual work in orthopaedic surgery and rehabilitation in Haiti.

In 1953, Dr. Funk first visited Ecole St. Vincent, a school for the handicapped in Port-au-Prince, because of his interest in the needs of orthopaedically handicapped children. In 1957, Dr. and Mrs. W. Larimer Mellon, Jr., brought the Albert Schweitzer Hospital to the Aritbonite Valley of Haiti. Since then, an orthopaedic surgeon from the Peachtree Orthopaedic Clinic has visited and worked at St. Vincent's, the Albert Schweitzer Hospital, and the House of Hope, a rehabilitation facility for children in the Haitian Northwest, every four months.

Sixth District

Beverly B. Sanders, Jr., M.D., of Macon was inducted into the Medical College of Georgia Founder's Club in Augusta.

Seventh District

Javed A. Butt, Jr., M.D., was recently certified as a Diplomate in internal medicine by the American Board of Internal Medicine in Philadelphia.

Eighth District

Douglas physician, **Otis R. Vickers, M.D.,** was inducted into the American College of Surgery in Chicago in October 1982.

Tenth District

Augusta physicians recently inducted into the Medical College of Georgia Founder's Club are **Marshall B. Allen, Jr., M.D., Taher Abdel El Gammal, M.D.,** and **A. Calhoun Witham, M.D.**

Highlights

MAG Executive Committee Meeting
February 13, 1983

Student and Resident Physician Members: The Executive Committee approved the text of a policy change regarding medical student membership. In the future, students will be charged an administrative and subscription fee of $10, and receive the *Journal, Newsletter,* and other Association mailings. The Constitution and Bylaws Committee will recommend to the House of Delegates in April that the MAG Bylaws be amended to reflect this provision.

The Executive Committee also approved raising dues for intern/resident members from $10 to $15. The Board of Directors will be asked to approve this change in April, and in turn submit it to the House for final approval.

Legislation: Dr. James Kaufmann, Chairman of the MAG Committee on Legislation, presented information on sixty health care bills in the General Assembly.

Mr. Robert Wesley, Executive Director of the Georgia Medical Care Foundation, reported that legislation had been introduced to transfer the federally mandated utilization review and quality of care certification process from GMCF to the Standards and Licensure Division of the Department of Human Resources. The Executive Committee agreed that the MAG should work toward defeat or amendment of this bill.

The Executive Committee also voted that MAG should work with GMCF to secure changes in legislation which would provide confidentiality of peer review activities regardless of source or object of civil action.

Dr. George Chastain, Chairman of the Composite State Board of Medical Examiners, requested MAG support in restricting prescription of amphetamines. The Executive Committee agreed to help ban the use of amphetamines in the state, or to seek more authority for the Composite Board in disciplining physicians for improper prescription of amphetamines.

Medicine and Human Values Committee: At the request of this Commitee, the Executive Committee agreed that the medical school curriculum should include instruction in moral, psychologic, and other aspects of death, so as to help future physicians better treat the critically and terminally ill.

Medical Students Meeting at the MAG House of Delegates: The Executive Committee approved a meeting during the House in April of medical students interested in organized medicine.

DHR Appalachian Recruitment Proposal: Mr. Tom Gibson, Director, DHR Primary Health Care Section, proposed that the MAG contract with DHR to develop a recruitment program for Appalachian Georgia. The Executive Committee directed that the MAG Access to Health Care Committee should work with DHR to develop a program for subsequent approval by the Executive Committee.

Appointment of Committee on Committees: The Executive Committee directed the appointment of a committee to discuss the MAG committee structure and the possibility of unnecessary committees, overlapping responsibilities, etc.

MAG Mutual Marketing and MAG Membership Plan: Mr. Bert Franco, Vice President for Marketing, MAG Mutual Insurance Company, proposed that MAG Mutual help resident physicians join the MAG by paying their membership dues and participating with the MAG in orientation sessions, benefit packages, etc., to resident physicians. The Executive Committee directed the MAG Membership Committee to work with MAG Mutual on this project.

MAG Leadership Conference Set for 1984: At the request of Dr. William Moore, MAG President-Elect, the Executive Committee voted to proceed with plans for a Second MAG Leadership Conference, to be held January 13-15, 1984, at the Waverly Hotel in northwest Atlanta.

Classifieds . . .

PHYSICIAN WANTED

The U.S. Department of Labor, Office of Workers' Compensation Programs seeks qualified medical specialists to serve as Medical Advisors and to review workers' compensation case files within their specialties. Qualifications: Board-Certified, eligible physicians only. Description: Work involves reviewing case files containing claims for benefits under the Federal Employees' Compensation act, and offering medical opinions in those files. The physician schedules his own hours and workplace. Fee negotiable. For further information call: Mr. Francis Hammond or Mrs. Manuella Hill, (404) 881-7812 or 7814, from 8:30 am to 5:00 pm, Monday through Friday.

Psychiatrist needed to assist the Chief Medical Officer in analyzing and evaluating the clinical programs in the Psychiatric, Medical/Surgical, Long-Term Care, and Mental Retardation programs at Central State Hospital, a large accredited, Medicare/Medicaid certified facility located in Milledgeville, GA. Georgia license required. Must be board certified or board eligible. Milledgeville is a beautiful Middle Georgia college town of approximately 15,000, only 2 hours from Atlanta, convenient to mountains and beaches, and immediately accessible to Lake Sinclair, a large hydro-electric lake which offers excellent recreational facilities. Excellent benefits: liberal sick and vacation leave, free malpractice and administrative liability insurance, health and life insurance, twelve (12) paid holidays annually, tax sheltered annuity, excellent retirement program, free parking. Salary negotiable. Call or write: Personnel Office, Central State Hospital, Milledgeville, GA 30162-9989. Phone (912) 453-4094. Equal Opportunity Employer.

Board-certified or board-eligible **pediatrician** to join a 4-pediatrician practice. Prefer pediatrician with extra training or interest in neonatology. Immediate opening. Salary with early partnership. Send resumé to: William B. Simmons, MD, 2115 Fourteenth St., Meridian, MS 39301.

Urologist — Rural Piedmont South Carolina community offers excellent opportunity for Board certified/eligible urologist. Community located between two metropolitan areas; 3 hours to beaches or mountains. JCAH accredited health care facility is newly renovated with modern equipment and excellent staff; 119 acute bed and 62 long-term care beds. Young aggressive medical staff open to new ideas and techniques. Send CV to Box 4-A, c/o *Journal.*

General Medicine Practice — Partner retiring. Excellent salary leading to full partner quickly. American graduates only. Reply to Box 4-B, c/o *Journal.*

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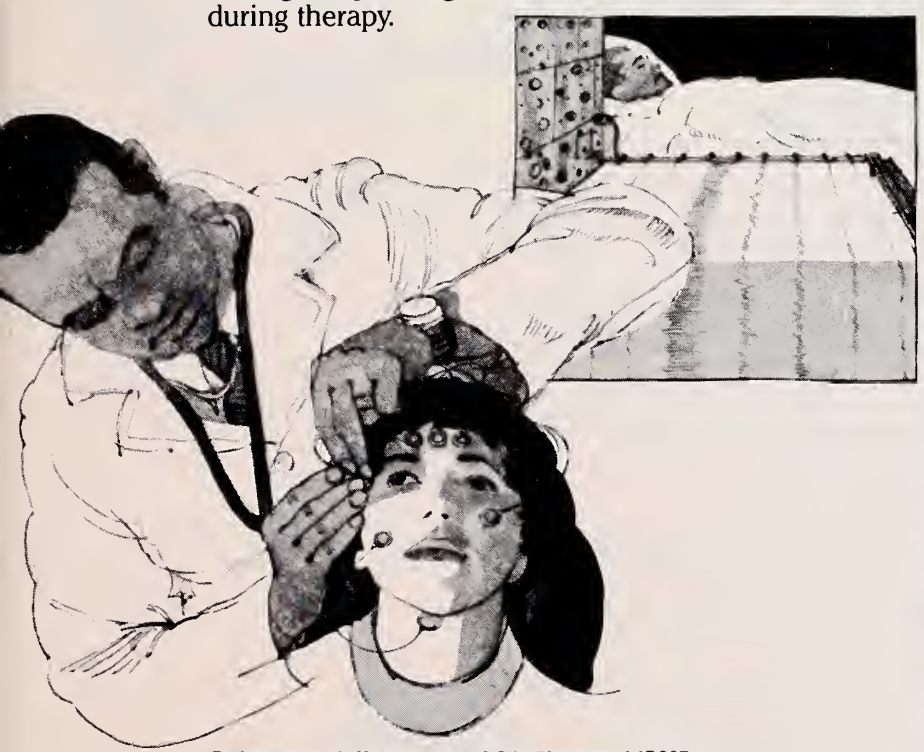
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References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

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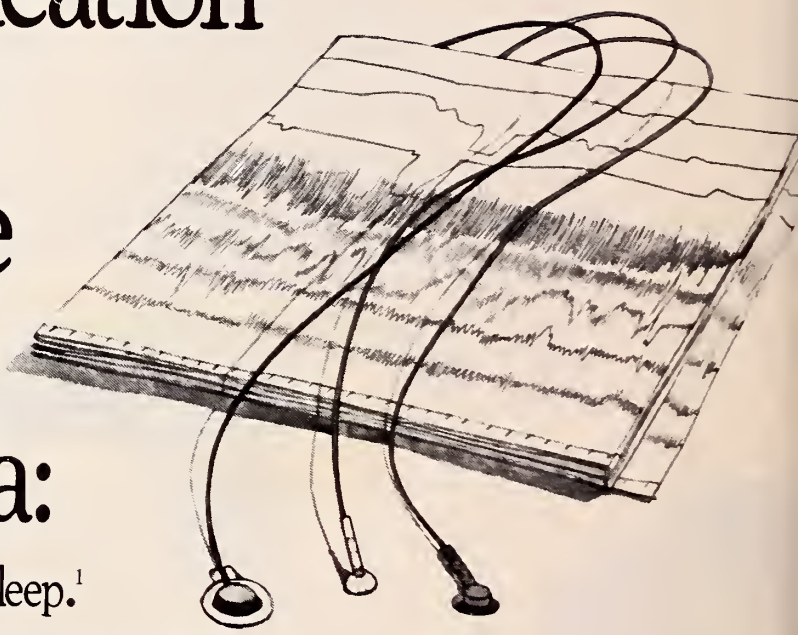
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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

Artwork by Richard Lyons, of Richard Heiman Advertising, Inc., Atlanta.

Incidental Intelligence . . .

Sudden Infant Death Syndrome

The occurrence of three cases of sudden infant death syndrome (SIDS) among siblings in a north Georgia family recently attracted considerable media attention. Although these deaths suggest a genetic predisposition to SIDS among members of this family, the etiology of SIDS remains unknown.

What Is SIDS?

SIDS is the sudden, unexpected death of an apparently healthy infant whose death remains unexplained after the performance of a complete autopsy. SIDS is the leading cause of death in the United States among children one month to one year of age, accounting for approximately 8,000 deaths a year (2.0/1,000 live births) nationwide and 160 deaths a year (1.6/1,000 live births) in Georgia.

Epidemiology

SIDS typically occurs during sleep and is more frequent during colder months. Most cases occur in children 1-4 months of age. Approximately 40-70% of children with SIDS have a mild upper respiratory tract infection. The syndrome is more common in males, in groups with low socioeconomic status, in low-birthweight infants, in subsequent siblings and surviving twins of SIDS patients, and in infants of younger or unmarried mothers. Other maternal features associated with an increased risk are smoking, delay or failure in seeking prenatal care, and drug abuse.

Etiology

The etiology of SIDS may involve several different mechanisms. Despite occasional clusters within families, in studies of twin survivors of SIDS patients, the risks are similar for mono- and dizygotic twins — discounting inheritance as a general explanation for SIDS. Recurrences within families may be related to pre- or postnatal environmental factors; genetic influences are probably less important. In studies where detailed postmortem examinations were performed, some patients were noted to have subtle markers of chronic hypoxia. This observation, as well as the presence of an abnormal breathing pattern in some children who died of SIDS, is the basis for intensive research into the control of respiration and for apnea monitoring programs. It should be noted, however, that the relationship between infantile apnea and SIDS has not been fully defined. Infant botulism has been recognized as the cause of a small percent of SIDS cases.

Psychologic Consequences

The occurrence of a sudden and unexpected death in a previously healthy infant can have an overwhelming psychologic impact on the family. Physicians, nurses, and social workers can play a key role in assisting families overcome their grief. Insensitive or inappropriate inquiries by neighbors, police, and health-care professionals may contribute to feelings of guilt.

In Georgia, local public health nurses are available to provide information and support for families who have recently lost a child to SIDS. Additional information on SIDS may be obtained by contacting the Georgia SIDS Project, Child Health Program, DHR, 47 Trinity Avenue, Atlanta 30334, (404) 656-4830.

(Contributed by Susan Williamson, RN, Georgia SIDS Project. Reprinted from the February, 1983, issue DHR's Georgia Epidemiology Report.)

Reference

1. Shannon DC, Kelly DH. SIDS and near-SIDS. N Engl J Med 1982;306:959-965, 1022-1028.

Murphy's Law(s) and Rabies in a Raccoon

What are the chances of:

1. A raccoon having an incubation period for rabies of 13 months?
2. A raccoon developing rabies even though its owner vaccinated it months before its death?
3. A raccoon developing rabies even though it was adopted as a pet before eye-opening (which occurs around 14 days of age) and had no subsequent exposure to wild animals until its death 13 months later?
4. A pet raccoon having rabies without its owner noting aggressiveness (furious) or paralysis (dumb) rabies before its death?
5. Obtaining a rabid raccoon as a pet from a person who shot its mother in a chicken house and sold the orphans by advertising on the bulletin board of a grocery store?

The chance of any one of the above happening is extremely remote, yet all recently occurred in Rockdale County. The diagnosis of rabies was confirmed in the raccoon on February 25, and three people are now receiving antirabies treatment following bites or scratches by this animal.

THE MORAL: DO NOT KEEP A WILD, CARNIVOROUS ANIMAL AS A PET — YOU NEVER KNOW WHEN IT MIGHT HAVE BEEN EXPOSED TO RABIES.

Although some zoological parks have routinely used inactivated rabies vaccines with the assumption that this will provide protection against rabies, no rabies vaccines are licensed for use in wild animals.

(*Reprinted from DHR's* Georgia Epidemiology Report, *February, 1983.*)

Operation Care, Inc. — Providing Medical Care for the Temporarily Unemployed

The MAG Executive Committee on March 13 enthusiastically endorsed and supports a program of providing medical care for the unemployed. The project will focus on those in the metropolitan Atlanta area who have lost their health care benefits because of their unemployment. The project, if successful, will serve as the pilot for similar programs in other parts of the state.

A nonprofit corporation, Operation Care, Inc., has been established so that donations may be solicited and accepted to provide medical care for the unemployed. Any monies raised will not be used to reimburse physicians for their time but will go to pay for items such as prescriptions and other costs not donated to the project.

Letters have been sent to over 2000 physicians in the Atlanta area asking for their participation in the program. The physicians have been asked to see and treat, on a rotating basis, patients who are "recession distressed." The patients will then be screened by volunteer Auxiliary members and nurses to help ensure that those referred to physicians fall within the guidelines of the program. These patients will then be referred to physicians who agree to participate in Operation Care.

Operation Care is not designed to be permanent in nature and is not an attempt to replace Medicaid or other programs benefiting the indigent. Its sole purpose is to take care of those productive citizens who have lost their jobs in a time of high unemployment and have thus lost their health care benefits.

The Georgia Department of Labor says there are nearly 20,000 such persons in a 12-county metropolitan Atlanta area. These are claimants, as defined by the Labor Department, have a work history, and are or have been eligible for unemployment compensation.

Operation Care, Inc., has been endorsed by the Medical Association of Atlanta Board of Trustees, the Cobb County Medical Society Executive Committee, the DeKalb Medical Society Board of Trustees, the Greater Atlanta Coalition on Health Care, Inc., and others.

Endorsements are being solicited from the Georgia Nurses Association, the Georgia Pharmaceutical Association, the Georgia Hospital Association, the Atlanta Chamber of Commerce, and major businesses throughout the Atlanta area.

Meetings are being held with dozens of hospital administrators to ask their support of the project. Physicians will be treating patients without charge. Some of these patients will require hospitalization. Hospitals are being asked to donate whatever beds and other services that they can provide to Operation Care.

We are asking pharmacists to cooperate by making prescriptions available at reduced costs. Pharmaceutical houses are being asked to donate the most commonly prescribed drugs.

Major employers are being asked to allow their laid-off workers to be treated by the company physician. In addition, they are being requested to contribute funds to the program.

The MAG, to our knowledge, is the first state medical society to have tackled such an ambitious undertaking. A number of county societies around the country have started similar programs.

Operation Care should begin taking calls and making referrals in early May. Should you have questions or need additional details on how such a program might work in your area, please call Mr. Ken Williams at the MAG, 1-800-282-0224 or 404-876-7535.

Rocky Mountain Spotted Fever, A Review of 1982 Cases and a Reminder for 1983

In 1982, 54 cases of Rocky Mountain Spotted Fever (RMSF) were reported in Georgia — a 29% decline compared to 76 reported cases in 1981, and a 13% decline compared to the 5-year median of 62 reported cases per year in 1977-1981. Nationwide, there were 979 reported cases in 1982 (preliminary data), compared to 1,192 in 1981, an 18% decline.

Of the Georgia patients in 1982, 48 (89%) were white, 37 (69%) were male, and 25 (47%) were <15 years of age. The first patient had onset of symptoms on April 14, 1982, and the last on November 30, 1982. The months of peak occurrence were May, June, and July, when approximately three-fourths of patients became ill. Fifty-one (94%) of cases occurred in persons living north of the Piedmont Fall Line.

Predominant symptoms included fever (100%), rash (83%), headache (74%), myalgias (65%), rash on palms and soles (57%), and nausea (17%). Forty-three (80%) were hospitalized, and two (4%) died. Forty-seven (87%) had a history of tick attachment or exposure to a known tick-infested area. Of the 25 patients for whom information was obtained, 21 (84%) owned a dog or had close contact with a dog, an animal which may serve as a transporter of the *Dermacentor* tick.

Thirty-nine (72%) of cases were confirmed either by isolation of the organism or by serologic testing. Fifteen (28%) were diagnosed on the basis of a single sera, clinical symptoms, and a history of tick attachment within the previous 14 days.

Editorial Note: With the approach of warm weather, physicians are urged to consider the possibility of RMSF in patients, especially children, with unexplained fever and rash. Tetracycline (for patients >8 years of age) or chloramphenicol are the antibiotics of choice; treatment should be started as soon as the diagnosis is suspected. In order to confirm the diagnosis, paired sera are required. The acute sera should be obtained immediately after onset of illness and the convalescent sera 14-21 days later. These specimens may be submitted to the Virology Laboratory, Georgia Department of Human Resources, for testing by the indirect-fluorescent-antibody method. A fee is charged for this test.

Physicians and hospitals are requested to report all cases of RMSF to their local health departments or to the Office of Epidemiology (404-656-4764).

(*Reprinted from DHR's* Georgia Epidemiology Report, *February 1983.*)

Kidney Foundation to Sponsor Educational Seminar on Burnout in the Medical Profession

On Saturday, May 21 from 8 a.m. to 4 p.m., the National Kidney Foundation of Georgia, in cooperation with the Georgia Council of Nephrology Social Workers, the Georgia Council on Renal Nutrition, the Georgia Renal Administrators, and the Dogwood Chapter of the American Association of Nephrology Nurses and Technicians will present Camille Maurice Wade's CARE FOR THE CARETAKER, a dynamic, educational experience on job burnout and stress management.

Camille Maurice Wade is a nationally known medical health consultant. In CARE FOR THE CARETAKER, she will help participants identify the signs, signals, and symptoms of burnout and teach practical techniques of reducing and preventing burnout. The seminar will be held at the Terrace Garden Inn, across from Lenox Square.

For a registration form, or for more information, call the National Kidney Foundation of Georgia at (404) 266-2350.

Correction Regarding DHR's Burn Treatment Program

In the "Incidental Intelligence" section of the April *Journal*, the Burn Treatment Program of DHR's Children's Medical Services was described. The person appointed as head of the team in Atlanta has been changed from Dr. Jurkiewicz to Dr. Roger T. Sherman. Emergency burn referrals should be directed to the admitting physician for the Grady Burn Unit (404) 588-4307. For direct communication with Dr. Sherman, call (404) 588-4307 and request the Grady operator to locate him by pager or at 588-3550, 588-3551.

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MEDICAL MEETING CALENDAR

MAY

18-22 — *Atlanta:* **Family Medicine Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-20 — *Columbus:* **Eleventh Annual Perinatal Medicine Conference.** Category 1 credit. Contact Div. of Perinatology, The Medical Ctr., P.O. Box 951, Columbus 31994. PH:404/324-4711.

27 — *Sea Island:* **Annual Meeting, Georgia Neurosurgical Society.** Contact Fremont P. Wirth, M.D., #4 Jackson Blvd., Savannah 31405. PH:912/355-1010.

JUNE

6-8 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus.** Category 1 and AAFP prescribed credits. Contact Patti McDuffie, R.N., Dept. of Med., Emory Univ. School of Med., 69 Butler St., SE, Atlanta 30303. PH:404/588-3721.

9-12 — *Sea Island:* **Annual Meeting of the Georgia Society of Dermatologists.** Category 1 credit. Contact Robert M. Kelleher, M.D., 6500 Vernon Woods Dr., NE, Ste. D-8, Atlanta 30328. PH:404/256-9400.

13-17 — *Lake Arrowhead:* **Orthopaedics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-23 — *Atlanta:* **2nd International Symposium on Legionella.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Orlando, FL:* **Arthroscopy Need Not Be Frustrating (Operative Arthroscopy).** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-2967.

JULY

11-12 — *Atlanta:* **MKSAP VI — Part III — ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Kiawah Island, SC:* **Clinical Obstetrics.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21 — *Hilton Head, SC:* **Clinical Cardiology.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

19-23 — *Hilton Head, SC:* **Sixth Annual Symposium on Contemporary Clinical Neurology.** Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

22-23 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

25-27 — *Kiawah Island, SC:* **Pediatric Update 1983.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

28-31 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

14-19 — *Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24-28 — *Hilton Head, SC:* **Summer Imaging.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

SEPTEMBER

11-14 — *Sea Island:* **Annual Meeting — Georgia Urological Association.** Contact Richard C. Estes, M.D., Secy.-Treas., 35 Collier Rd., NW, Atlanta 30309. PH:404/355-0813.

12-14 — *Atlanta:* **Echocardiography.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Savannah:* **Neonatology.** Category 1 credit. Contact Div. of Cont. Ed., Med. Coll. of Ga., Augusta 30912. PH:404/828-3967.

15-17 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, M.D., Secy.-Treas., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

26-29 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

6-8 — *Hilton Head, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

8-12 — *Atlanta:* **American Society of Anesthesiologists.** Contact ASA, 515 Bussee Hwy., Park Ridge, IL 60068. PH:312/825-5586.

10-13 — *Atlanta:* **ACC Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-21 — *Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

22-27 — *Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P.O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

Letter to the Editor . . .

Regarding Napoleon Bonaparte

Dear Sir:

The reprint of Dr. Walter R. Holmes' article, "The Illness and Death of Napoleon" [March, 1983, *JMAG*] is startling not so much for its revelation that he died of cancer of the stomach complicated by Malta fever, but rather for the astounding fact that at autopsy he measured 5′10″ in length. Since Napoleon's size has been offered as an important criterion in the diagnosis of the "Little Napoleon Complex" this revelation may come as a surprise to epidemiologists involved in the study of the incidence of such psychiatric disorders in the general population. Since Dr. Holmes was a Professor of Gynecology at Emory University, home of a famous Methodist seminary, perhaps it is worth mentioning that John Wesley, who preached here in Savannah at Christ Church for a short period of time, stood only 5′1″ and weighed 120 lbs. Nonetheless, Savannahians have seen fit to erect an 8′ statue to the memory of the founder of Methodism. Be that as it may, wouldn't it seem more appropriate to rename the "Little Man" syndrome in honor of Wesley, who by all accounts was a doughty and feisty character?

Sincerely,
Mason G. Robertson, M.D.
Internist, Savannah
March 25, 1983

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CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, mebutamate, or carbromal.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.
MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred.
Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12-to-48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.
POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.
ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical cord blood at or near maternal plasma levels and in breast milk at lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.
USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic®-M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.
MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.
MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.
GI: Nausea, vomiting, diarrhea.
CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.
ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate mebutamate and meprobamate/carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.
HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.
OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.
3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.
10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.
At levels greater than 20 mg percent, more fatalities than survivals can be expected.
Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.
In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.
Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

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JOURNAL
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The Direct Hematopoietic Toxicity of Ethyl Alcohol

TROY H. GUTHRIE, JR., M.D., and JOHN B. BECKMAN, M.D., *Augusta**

Abstract

Major advances have been made in the understanding of ethyl alcohol's role as a direct hematopoietic toxin. The problem of separating associated nutritional deficits and alcoholic liver disease from ethyl alcohol's truly toxic influence on hematopoietic cells is difficult, but carefully controlled studies in volunteers indicate a profound effect of ethyl alcohol on both mature and immature red cells, granulocytes, and thrombocytes.

Alcoholism and medical problems associated with alcohol abuse consume a large portion of the national health dollar. According to a government report, alcoholism and alcohol abuse either directly or indirectly cost $12.74 billion, or 12.1% of all money spent on health care in 1975.[1] In the same year, it was estimated that alcohol was involved in 205,000 deaths, or about 11% of all deaths.[1] The morbidity associated with alcohol abuse is not known, but surely it must be high.

The effects of alcohol on the human organism are protean. The damage to the various organ systems are interrelated, such that it has not always been possible to distinguish the direct effect of alcohol on a specific system from the effects caused indirectly. The hematopoietic system suffers a wide variety of abnormalities as a result of chronic alcohol abuse. These abnormalities are complex, and in spite of much progress in recent research addressing the problem, the exact mechanism by which alcohol exerts its effects is not clear. In general, alcohol effects the system in three ways: (1) the direct toxic effect of alcohol, (2) the hematologic results of the nutritional deficiencies commonly experienced by the alcoholic, and (3) indirectly through the damage incurred by other organ systems, such as the liver and spleen, which in turn cause abnormalities in the hematopoietic system. In this review, we will examine the direct effects of alcohol on the hematopoietic system.

* Dr. Guthrie is Assistant Professor of Medicine, Hematology/Oncology, and Dr. Beckman is a resident in internal medicine, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to Dr. Guthrie.

Alcohol Metabolism

All but 2-10% of alcohol ingested is metabolized in the liver[2] into two main by-products, hydrogen and acetaldehyde, the latter of which is further converted into acetate. There are two enzyme systems which are responsible for the first reaction: alcohol dehydrogenase and the microsomal ethanol oxidizing system. Both of these systems involve oxidation-reduction reactions in which ethanol is oxidized to its two by-products and nicotinamide adenine dinucleotide (NAD) is reduced. The result is an increased NADH/NAD ratio which accounts for many of the metabolic derangements caused by alcohol.[3, 4] Functionally and morphologically, there is disruption in the mitochondria, the rough endoplasmic reticulum, the cell membrane transport and permeability, and the levels of intracellular enzymes.[5] The subsequent unavailability of NAD inhibits enzymatic reactions dependent on it for occurring, such as oxidative phosphorylation and the reactions in the citric acid cycle.[6] This in turn accounts for many of the derangements caused by alcohol. In the process, up to 90% of all other substrates of liver metabolism are displaced by ethanol.[7] This effect is limited in that this abnormal redox potential is attenuated once a fatty liver has developed.[8] Since the metabolic derangements continue after this event, other mechanisms must be involved. Ethanol

has an inhibitory effect on liver protein synthesis[9] and may also inhibit secretion of protein from the cell.[10, 11] This has been disputed recently, however.[12]

The first by-product of ethanol metabolism, acetaldehyde, also has considerable adverse effects of its own. It is oxidized to acetate by aldehyde dehydrogenase which reduces more NAD, thereby furthering the derangements caused by the abnormal NADH/NAD ratio. Acetaldehyde in itself has been shown to inhibit protein synthesis.[13] A specific reaction that acetaldehyde is known to influence is the increased hydrolysis of pyridoxal 5′-phosphate by cellular phosphatase.[14]

Derangements in Specific Blood Cell Lines

The following is a discussion of the effects that alcohol has on specific blood cell lines (Table 1). First, we will discuss an effect that prolonged ethanol ingestion has on the bone marrow precursors of all cellular blood components. Following that will be a discussion of the effects on the erythrocyte, leukocyte, and platelet cell lines.

Vacuolization of Marrow Precursor Cells

One effect seen as a direct toxic result of alcohol is the appearance of vacuolated nucleated bone marrow cells after 5-7 days of drinking 0.5-1.0 qt. of 86 proof alcohol or its equivalent.[15, 16] This change occurs in both erythrocyte and leukocyte precursors[15] and is not associated with anemia or any change in the cellularity of the marrow or the peripheral cell morphology.[17] This change disappears 3-7 days after cessation of ethanol ingestion.[15] Attempts to characterize or determine the significance of vacuolization have been unsuccessful to date.[17, 18] This change in bone marrow cells has been seen in several other clinical conditions including chloramphenicol-induced aplastic anemia, various nutritional deficiencies, certain drugs, and some metabolic derangements. Any correlation between these conditions and the alcohol-induced change, however, has not been found.[17]

TABLE 1 — Summary of Effects on Specific Blood Cell Lines

Cell Type	*Effect*	*Proposed Mechanisms*
Bone marrow precursors	Vacuolization	Unknown
Erythrocytes	Megaloblastic anemia	Impaired enterohepatic circulation of folate
		Inhibition of tetrahydrofolate formylase
		Inhibition of formate incorporation into marrow cells
	Macrocytosis	Unknown
	Sideroblastic anemia	Increased hydrolysis of pyridoxal 5′-phosphate
Leukocytes	Leukopenia	Combination of host specific factor and unknown dietary deficiency
Platelets	Thrombocytopenia	Decreased production, decreased entry into circulation, and increased destruction

Red Blood Cells

Chronic alcohol consumption has numerous effects on the erythrocyte series, many of which are difficult to separate from the effect of nutritional deficiencies seen in alcoholics or the effect of damage to other organ systems. The following is a discussion of several changes seen in erythrocytes as a result of the direct toxic effect of alcohol. The proposed mechanisms by which these changes may occur will also be briefly discussed.

Megaloblastic Anemia

Megaloblastic anemia is the most common anemia found in alcoholics admitted to the hospital acutely ill, with 40% of them manifesting some degree of this abnormality.[15] While folate deficiency plays a major role in the evolution of this anemia, there is considerable evidence that alcohol by itself is a factor in the development of megaloblastic anemia. There is poor correlation between the level of liver dysfunction and the degree of anemia. Megaloblastic anemia is rare in non-alcoholic liver disease.[19] Megaloblastic changes in bone marrow revert to normal with cessation of alcohol intake without replacement of folate.[15, 20] In alcoholics who continue to drink, physiologic amounts of folate replacement fail to correct megaloblastic anemia, but much larger doses will.[16] Megaloblastic anemia cannot be induced in alcoholic volunteers maintained on a nutritious diet and allowed to drink.[18] It can, however, be induced by feeding a folate deficient diet in volunteers.[15, 21] The induction of the anemia is much faster when the volunteers are given alcohol.[15] Lastly, ethanol ingestion can inhibit the marrow response to parenteral folic acid, suggesting that the effect is a directly toxic one rather than a disturbance in absorption.[16]

The mechanism by which alcohol inhibits folate metabolism and causes megaloblastic changes is unclear, but several ideas have been investigated. There is a considerable decrease in liver folate levels and an increase in urinary folate excretion during alcohol ingestion.[22] This suggests increased folate excretion as a factor. There is a rapid decrease in serum folate levels within hours after ethanol ingestion, and there is evidence that alcohol inhibits the enterohepatic circulation of folate.[19] Finally, alcohol may inhibit folate metabolism by blocking the

enzyme, tetrahydrofolate formylase, and may inhibit the incorporation of formate into marrow cells.[22]

Macrocytosis of Alcoholism

In 1974, Wu, et al.[23] described a macrocytosis seen in 89% of all alcoholics. Macrocytosis is the most common cause for an increased mean corpuscular volume seen in hospitalized patients.[22] Anemia is slight or absent, and the macrocytosis occurs in the absence of cirrhosis, splenomegaly, or folate deficiency.[23] The macrocytosis is present without megaloblastosis, and the red cell indices return to normal in 2-4 months with abstention from alcohol.[23] Evidence that this macrocytosis is poorly correlated with the presence and degree of liver dysfunction[23, 24] includes (1) failure to improve with either folate or B_{12} replacement[23] and (2) the severity parallels the amount of ethanol ingested.[22]

Sideroblastic Anemia

Sideroblastic anemia is the second most commonly seen anemia in acutely ill alcoholics, with 30% presenting with this abnormality.[15, 21] Again, vitamin deficiency seems to be the major cause for this anemia, but alcohol also plays a part in its development. Sideroblastic anemia is only seen in malnourished alcoholics[15, 21] and can be induced with a diet deficient in B_6 in alcoholic patients who are allowed to drink[15, 21, 25] but not in alcoholics who continue to drink but are fed a nutritious diet.[18] The anemia is resolved in patients who present with sideroblastic anemia and are given B_6 replacement but continue to drink.[15, 25] There is evidence that acetaldehyde plays a role in the development of the anemia by causing an increased hydrolysis of a B_6 metabolite, pyridoxal 5-phosphate by cellular phosphatase. This inhibits hemoglobin synthesis, since this metabolite is a co-factor in several of the enzymatic steps in hemoglobin synthesis.[14] Several other enzymatic reactions in hemoglobin synthesis may be inhibited by ethanol or its by-products but these have not been well described yet.[19]

Hemolytic Syndromes in Alcoholism

Alcohol directly or indirectly causes three distinctly different hemolytic syndromes.[26] The first is very mild and is associated with the presence of target cells. It is probably an extension of the macrocytosis of alcoholism previously described.[19] The hemolysis results from the accompanying splenic congestion and does not appear to be a direct result of alcohol ingestion.[26] A second type of hemolysis is associated with protal hypertension and acute splenic congestion. As with the other two syndromes, it is not responsive to steroid therapy and is generally Coomb's Test negative. Cells transfused into these patients have a shortened life span, indicating that an as yet undefined humoral factor is probably present.[27] The third type of hemolysis is associated with cirrhosis, splenomegaly, hyperbilirubinemia and the appearance of spur cells. The genesis of hemolysis is unclear, but there is an associated increase in the cholesterol/phospholipid ratio in the cell membranes and in the serum of these patients.[26] The role that alcohol plays in the development of this abnormal ratio and the subsequent syndrome is not known nor is it known why some patients with similar lipid abnormalities do not develop spur cells and accompanying hemolytic syndrome. The presence of hyperbilirubinemia seems to be important, since it is present when the syndrome develops and is absent when it does not.[26]

White Blood Cells

The leukocyte series is also directly effected by alcohol with a 3.6-8.5% incidence of leukopenia among acutely ill alcoholics.[15, 28, 29] The condition is transient, with the white cell count reverting to normal in 2-4 days after cessation of ethanol ingestion.[30] Leukopenia can be present whether there is a concomitant infection[30] or not.[29] Leukocytosis cannot be induced by endotoxin administration.[30] The leukopenia is not related to folate deficiency and in fact has developed in patients undergoing folate replacement.[29] The mechanism by which leukopenia develops is unclear, but it does not develop in well nourished alcoholics,[16, 18] and it is not related to the presence of infection, splenomegaly, or megaloblastic anemia.[31] It cannot be induced in alcoholic volunteers who are fed a nutritious diet and are allowed to drink.[18] The development of leukopenia seems to be a combination of alcohol ingestion, an as yet undefined dietary deficiency, and a unique host factor. Certain patients seem to be particularly susceptible to leukopenia, and it frequently appears repeatedly in the same patients each time they drink while it never develops in other patients under similar circumstances.[29]

Leukocyte function may also be effected by alcohol, but there is some disagreement about this. Some authors[32, 33] report that leukocyte mobilization is impaired, while others dispute this.[34, 35] Leukocyte adherence is also controversial in that some claim that alcohol inhibits adherence[33] and others disagree.[35, 36] Alcohol does not seem to effect phagocytosis or intracellular killing by leukocytes.[32]

Hemostasis

Chronic alcohol ingestion is associated with abnormalities in platelet production and blood clotting. However, in the absence of liver dysfunction, there are no significant coagulation defects involving humoral factors.[37, 38] Bleeding time is twice normal with normal numbers of platelets and is four

to five times normal in thrombocytopenic patients after ethanol ingestion.[39] The incidence of thrombocytopenia in acutely ill alcoholics is 14-81%[15, 40] and in healthy, ambulatory, working alcoholics is 3%,[28] indicating that thrombocytopenia is partly secondary to the direct effect of alcohol. Although a significant number of alcoholics are thrombocytopenic, there is no relationship between the degree of thrombocytopenia and the degree of liver dysfunction.[15, 41] Alcohol seems to directly cause thrombocytopenia and the degree of liver dysfunction[16, 18, 38, 42] and depression of blood platelet levels was the only abnormality to consistently develop in alcoholics who were fed a nutritious diet and allowed to drink.[18] The effects that alcohol produces include decreased platelet production, impaired delivery of platelets to the circulation and decreased platelet survival.[16] The mechanism by which these abnormalities develop is not understood but is probably related to deranged folate metabolism described above.[41]

Summary

The exact link between alcohol metabolism and its effect on the hematopoietic system is unclear but probably is mediated through three mechanisms: (1) the altered redox potential generated which causes numerous metabolic abnormalities in lipid, carbohydrate, and protein metabolism, (2) the direct effect of alcohol on enzymatic reactions involved in protein synthesis, and (3) the direct effect on the function of the cells in the hematopoietic system.

Ethanol causes vacuolization of the nucleated bone marrow precursor cells. The significance of this is not known.

Megaloblastic anemia is caused by a combination of folate deficiency and the direct effect of ethanol on folate metabolism which includes impairing the enterohepatic circulation of folate, the increased excretion of folate, inhibition of tetrahydrofolate formylase, and the blocking of formate incorporation into marrow cells.

There is a macrocytosis of alcoholism which is not associated with anemia or megaloblastosis and whose significance is not understood.

Sideroblastic anemia is caused by a combination of vitamin B_6 deficiency and a direct effect of alcohol, probably by interrupting hemoglobin synthesis by increasing the hydrolysis of pyridoxal 5′-phosphate.

Three hemolytic syndromes are associated with alcoholism, but these are likely to be secondary to the liver damage seen and not as a direct result of alcohol.

There is a leukopenia seen in some alcoholics that appears to be caused by a combination of a direct effect of alcohol, an as yet unknown dietary deficiency, and a unique host factor seen only in those who develop the leukopenia. There may or may not be a disturbance in leukocyte mobility and adherence, but there seems to be no effect of alcohol on phagocytosis or intracellular killing.

Ethanol inhibits platelet production, entry into circulation, and is associated with increased platelet destruction.

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(Continued on page 328)

Conservative therapy is essential as disc injection with chymopapain is not without potentially significant complications.

Chemonucleolysis for Herniated Nucleus Pulposus

RICHARD S. RIGGINS, M.D., and THOMAS E. WHITESIDES, M.D., *Atlanta**

THE CAUSES OF PAIN in the low back are as varied as the treatments prescribed. In 1934, Mixter and Barr[1] described one cause of low back pain: herniation of the nucleus pulposus of the intervertebral disc. Disc herniation will sometimes impinge on a nerve root extending into the lower extremity, causing pain in the low back with radiation into the lower extremity. Removal of this disc material will appreciably relieve the leg component of the pain, but has a much less predictable effect on the back component of the pain. Since removal of the herniated nucleus pulposus does nothing to correct the mechanical dysfunction of the lower spine, it is quite unreasonable to expect that removal of this material will predictably relieve lower back pain.

In 1963, Smith[2] reported that chemical dissolution of the nucleus pulposus can relieve the lower extremity pain associated with disc herniation. Smith used a purified enzyme from the papaya, chymopapain, which attacks the proteoglycans of the disc, causing a loss of disc substance plus water.[3] Reducing the size of the disc by loss of proteoglycans and water relieves the pressure on the nerve root, thus relieving the pain in the lower extremity. After a very careful clinical trial supervised by the Food and Drug Administration to demonstrate the drug's effectiveness and safety, the enzyme is now available for physicians trained in its use.

Indications

The indications for use of chymopapain in herniation of the nucleus pulposus are similar to those for surgery. The patient should have lower extremity radiating pain as a significant component of his symptoms. Radicular pain is the only symptom that can reasonably be expected to be relieved by the injection. Naturally, the root compression must be secondary to a herniated nucleus pulposus and not to bony overgrowth about the facets, vertebral malalignment, tumor, or other causes of nerve root impingement. Furthermore, the patient should have failed an adequate trial of conservative therapy, as disc injection with chymopapain is not without potentially significant complications.

Technique

Although there are a number of minor variations in technique, the presently recommended procedure requires the patient to be hospitalized and for the injection to be done under general endotracheal anesthesia. Through a lateral approach under fluoroscopic control, needles are inserted into the involved disc spaces. Radiopaque material is injected into the disc to control needle placement and to demonstrate the disc abnormality. After confirming the position of the needle, the enzyme is injected and the needle removed. Postoperatively, the patient is allowed activity as tolerated and may be discharged when comfortable. Significant post injection back pain and muscle spasm may occur in 35-50% of the patients for several days, requiring strong narcotics for relief. Soreness and pain in the low back secondary to the injection may last 3-6 weeks after the injection. The radicular pain is usually relieved much more rapidly.

Complications

The most serious complications associated with chymopapain injections have been anaphylactic

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shock and anaphylactoid reactions. The incidence has been 2.5% in females and 0.18% in males.[7] There have been several deaths resulting from injections of this foreign protein; hence, the need to carry out the procedure under endotracheal anesthesia in a well equipped area with trained personnel capable of managing profound cardiopulmonary collapse. Patients with strong allergic histories or known sensitivity to papaya, meat tenderizer, beer, or iodine should not receive chymopapain. For reasons not understood, females are more apt to suffer an anaphylactic reaction than males, and females with elevated erythrocytes sedimentation rates (ESR) have such a high incidence of allergic response that the use of chymopapain in such females is contraindicated.[3] Patients with previous injections of chymopapain may be sensitized to the protein and should not receive a second injection. Previous surgery at the suspected level is also considered a contraindication for chymopapain injection. As previously mentioned, patients with pain predominately in the back and patients who have radicular pain from causes other than herniated nucleus pulposus will not respond to disc injections with chymopapain.

Chymopapain is commercially available from the Smith Laboratories as Chymodiactin®. This is a more purified form of the enzyme than originally marketed by Baxter-Travenol Laboratories under the trade name, Discase.® Chymodiactin® is prepared from the crude latex of carica papaya. Sodium L cysteinate hydrochloride is added as a reducing agent, and the pH of the reconstituted drug from its powder form is 5.5 to 6.5.[9] The enzyme appears to be active only against proteoglycans and has no effect on collagen.[3] It binds quickly to the disc material after injection. It is also rapidly inactivated by blood and serum.[4] Animal experiments have failed to show any adverse affect of Chymodiactin® on peripheral nerves, large blood vessels, or collagen structures such as the annulus of the intervertebral disc.[4, 5] Intrathecal injections of Chymodiactin® have proven to be very toxic in animals. The intrathecal capillary network is damaged, causing a profound increase in the cerebrospinal fluid pressure, convulsions, and death. Venting the CSF has salvaged many of the animals.[6]

Summary

With the recent release of Chymodiactin® by the Food and Drug Administration, a new approach for treating herniated nucleus pulposus in the lumbar spine is now available. Chymodiactin® is a proteolytic enzyme which when injected into the intravertebral disc causes loss of water and proteoglycans from the disc. This reduces the size of the herniated material and relieves the pressure on the nerve root. Injection of this foreign protein into the disc is not without potentially significant complications, and several deaths from anaphylactic shock have been reported.[8] Considerably more clinical experience with chemonucleolysis with chymopapain will be needed to establish its superiority to surgical removal of the herniated nucleus pulposus.

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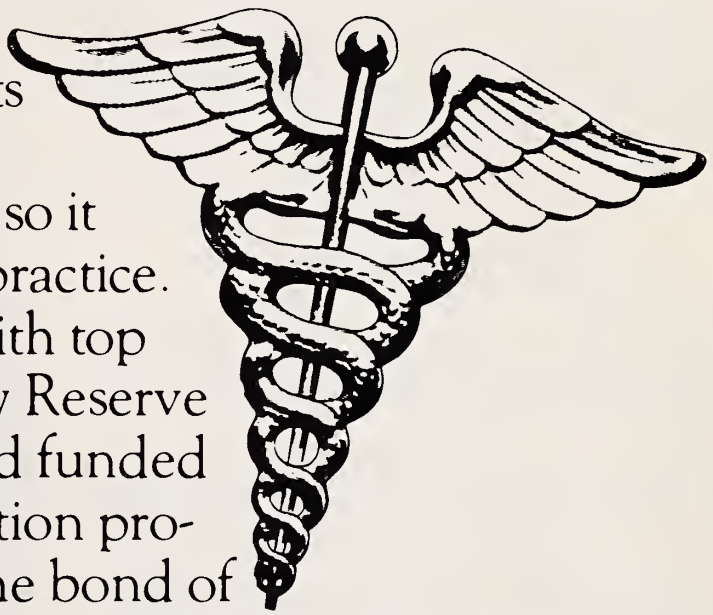
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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nitedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

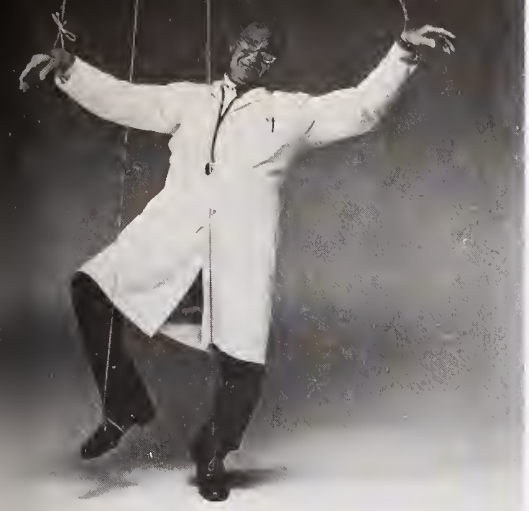
In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



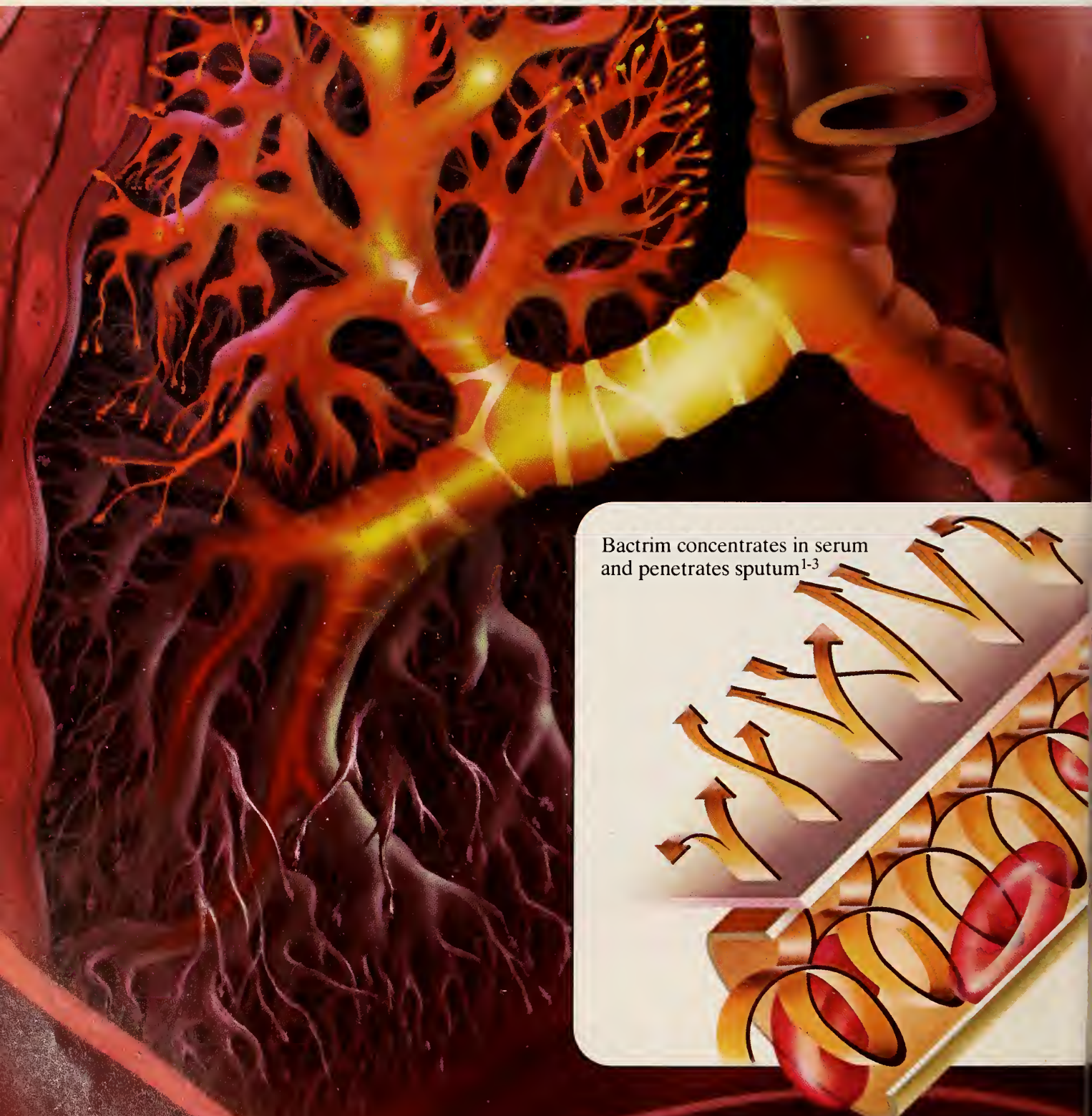
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*Procardia is indicated for the management of:
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Please see PROCARDIA *brief summary on adjoining page.*

Bactrim™ attacks the
(trimethoprim and sulfamethoxazole/Roche)
in acute exacerbations



Bactrim concentrates in serum and penetrates sputum[1-3]

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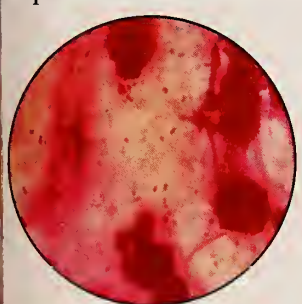
major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

tacks *H. influenzae*—even
ampicillin-resistant strains



attacks *S. pneumoniae*



Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1*/2:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection* 6(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

Economical b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. **Please see next page for summary of product information.**

Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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The author reports a case successfully treated in a 13-month-old girl and reviews current approaches to clinical and histopathologic diagnosis, staging, and multi-disciplinary treatment.

Sarcoma Botryoides (Embryonal Rhabdomyosarcoma)

JOHN L. POWELL, M.D., *Atlanta**

"Diseases desparate grown by desparate appliances are reliev'd or not at all"
Shakespeare
Hamlet, Act 4, Scene 3

Introduction

Sarcoma botryoides of the genitourinary tract is a rare and highly malignant polypoid tumor which is seen almost exclusively in young girls. This tumor used to be considered uniformly fatal in 90% of cases. In the past 2 decades, a notable change has occurred in our concepts about the proper modality of treatment. As a result, the prognosis has also changed. The author reports a case successfully treated in a 13-month-old girl and reviews current approaches to clinical and histopathologic diagnosis, staging, and multi-disciplinary treatment with surgery, irradiation, and combination chemotherapy. This is undertaken to provide more detail about the clinical features as well as the proper treatment of this neoplasm, in hopes of increasing awareness among all physicians involved with the treatment of children in Georgia.

Case Report

THIS 13-MONTH-OLD, 22 lb., black female referred in January, 1980, was the product of the mother's second pregnancy via a normal, spontaneous vaginal delivery on December 8, 1978, after an uncomplicated gestation. The mother detected a 3 cm polypoid mass protruding from the urethra in early January, 1980. Initially, this lesion was only visible when the patient was straining to have bowel movements or void (Figure 1). A biopsy of these grape-like clusters of soft, fleshy tissue was interpreted as sarcoma botryoides (embryonal rhabdomyosarcoma) with an edematous myxoid stroma containing a distinct "cambium" layer and eosinophilic strap cells, with unmistakable cross-striation and an overlying stratified epithelial surface (Figure 2). Chest X-ray, lung tomograms, IVP, SMAC, bone marrow aspirate, bone scan, and liver/spleen scans were normal. Cystourethroscopy, vaginoscopy, and cystogram under anesthesia revealed involvement of bladder and urethra (Figure 3). The rectum was not involved, and there were no enlarged groin or supraclavicular lymph nodes. The patient was registered with The Intergroup Rhabdomyosarcoma Study and initially placed on the "VAC" chemotherapy protocol. She was reevaluated after two courses of combination chemotherapy revealing only partial regression. Because of persistent gross polypoid tumor masses in her bladder, the patient underwent an exploratory laparotomy, peritoneal cytology, bilateral pelvic and periaortic lymphadenectomy, anterior exenteration, including radical hysterectomy, cystectomy, urethrectomy, anterior vaginectomy with vaginal reconstruction, bilateral lateral ovarian transplant, appendectomy, and formation of a non-refluxing sigmoid-urinary conduit (technique of Hendren[17]) (Figure 4A-E). Pathology revealed localized malignant disease, completely resected, with negative peritoneal cytology and uninvolved regional lymph nodes (Group I) (Table 1). The child was discharged on the 14th postoperative day, after an uncomplicated hospital course. She was maintained on antimicrobial ther-

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Figure 1 — Sarcoma botryoides of vagina and urethra. The gross appearance is that of a confluence of polypoid masses resembling a bunch of grapes.

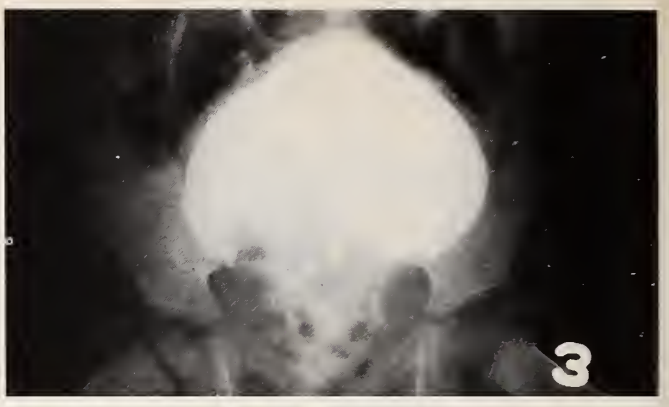


Figure 3 — Cystogram demonstrating that the superior portion of the bladder is normal and the inferior portion shows multiple small clusters of nodular filling defects characteristic of sarcoma botryoides.

apy (Trimethoprim and Sulfamethoxazole) for 2 months. She received 18 months of combination chemotherapy with Vincristine, Cytoxan, Actinomycin-D, and Adriamycin (See Table 2 for regimen and dosages that alternated on a monthly basis). She did not receive any external beam radiotherapy. Twelve months following the exenteration, she underwent a staged ureterosigmoidostomy in which the sigmoid conduit was implanted into the rectosigmoid colon (Figure 4F). No evidence of recurrence was detected at surgery or in subsequent follow-up. Chest x-rays, abdominal ultrasounds, CAT scans, and regular interval examinations have also failed to reveal a recurrence. She has had no urinary tract infections, and IVP, BUN, and creatinine have remained stable. She has excellent control of urine by rectum.

Growth and development have been normal. This child has been off all chemotherapy for 18 months without recurrence (Figure 5). We are optimistic

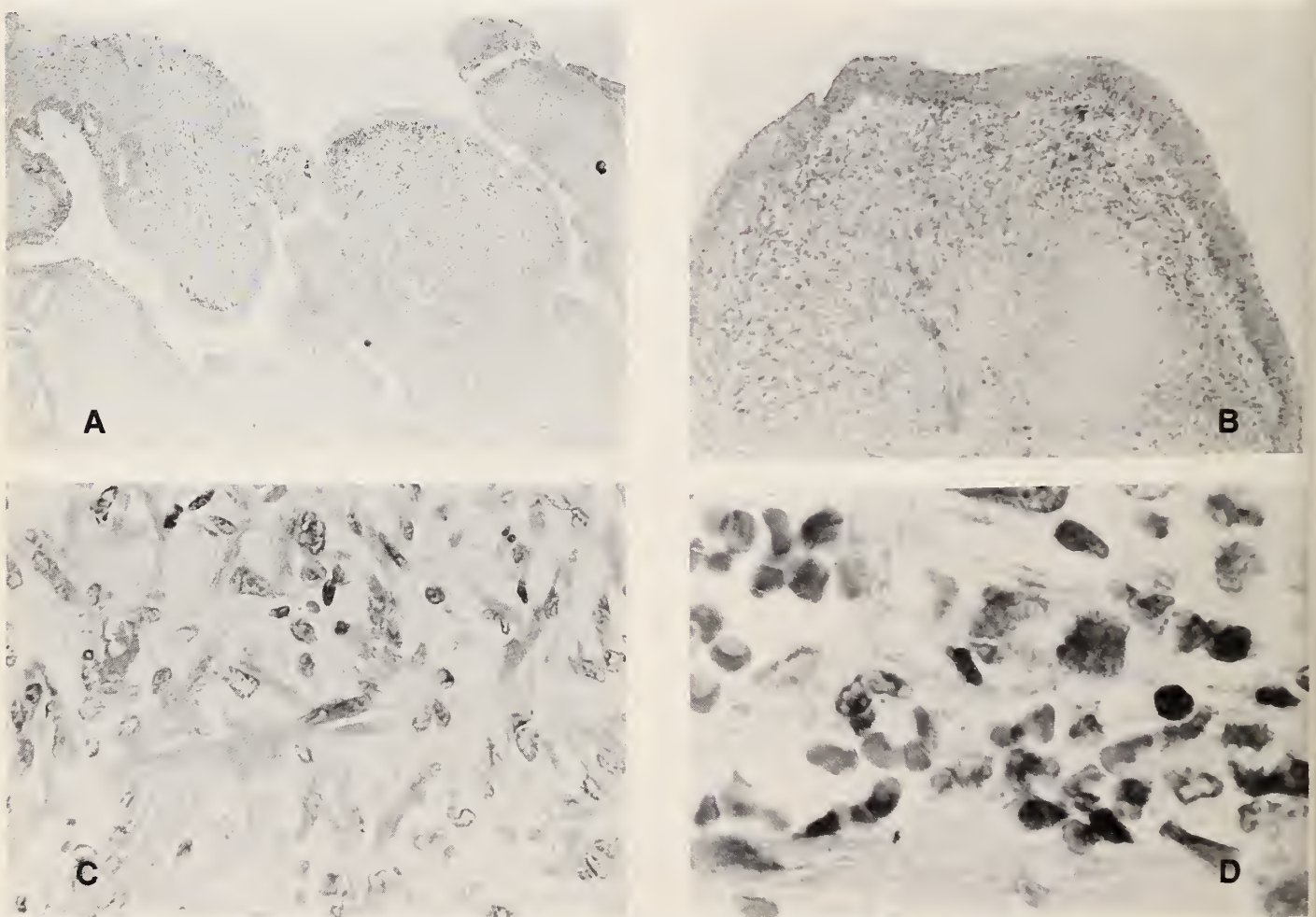


Figure 2 — Sarcoma botryoides. A. Cross section of polypoid lesion (× 10) B. Undifferentiated round and spindle cells make up the cambium layer beneath the epithelium (× 100) C. Myxoid stroma (× 450) D. Striated muscle cells (× 1000).

about her future and anticipate that she will continue to mature in the normal female manner.

The author wishes to acknowledge the participation of Dr. Elna T. Phelan in the chemotherapeutic and Dr. Thomas S. Parrott in the urologic management of this patient.

Discussion

Sarcoma botryoides is an extremely rare tumor, found mostly in infants and young children. The annual incidence of rhabdomyosarcoma in the United States is estimated to be 4.4 per million white children under 15 years of age. For black children, the annual incidence is 1.3 per million children under 15 years of age.[1] The peak incidence is between 1 and 2 years of life, with 90% of cases seen in girls under 5 years of age and almost two-thirds within the first 2 years.[2] A few appear following menarche; however, a greater percentage of tumors developing in this age group probably arise in the uterus rather than in the vagina.[3] Similar tumors have been described at other urogenital and extraurogenital sites, including bladder, prostate, anus, biliary tract, and nasopharynx.

Pathology

This tumor originates from the undifferentiated mesenchyme of the subepithelial connective tissue layer (lamina propria) of the vagina. The gross appearance of the initial pelvic examination is that of a confluence of polypoid masses resembling a bunch of grapes, as its name "botryoid" implies (Figure 1). When the tumor looks like a simple polyp, it is easy for the medical attendant to be lulled into a false sense of security and to believe it to be benign. This tumor arises most commonly from the lower two-thirds of the anterior vaginal wall. The proximity of an anterior vaginal wall lesion to the vesicovaginal septum and the posterior bladder wall makes these areas highly vulnerable to infiltration. Characteristically, the growth pattern begins with expansile intraluminal growth, later extending into the paravaginal connective tissues. Important in designing therapy is recognizing that this tumor can infiltrate along tissue planes beyond its apparent clinical margins. Although it can metastasize to any site, it spreads most frequently to the regional lymph nodes, lungs, and liver. Histologically, one sees an edematous myxoid stroma and an overlying stratified epithelial surface (Figure 2). Crowding of tumor cells beneath the vaginal epithelium results in a distinct subepithelial dense zone referred to as the cambium layer. Pleomorphism is always a marked feature. The most important distinguishing feature and the sine qua non for diagnosis is the presence of eosinophilic cross-striated muscle fibers (rhabdomyoblasts). Characteristically, round, racket or strap-shaped forms may be identified. Bone, cartilage, osteoid, fat, and malignant epithelium, usually associated with a mesodermal mixed tumor, are not found. It will be evident that many of these histologic features do not strongly suggest malignancy, and in many instances the appearances are those of a simple polyp, a diagnosis which has been made initially many times in the past and has been the reason for considerable delay in undertaking proper treatment.

TABLE 1 — Staging Systems for Childhood Rhabdomyosarcoma

INTERGROUP RHABDOMYOSARCOMA STUDY[5]	
Group I:	Localized disease, completely resected. Regional nodes not involved. (a) Confined to muscle or organ of origin. (b) Contiguous involvement-infiltration outside the muscle or organ of origin, as through fascial planes. Inclusion in this group includes both the gross impression of complete resection and the microscopic confirmation of complete resection.
Group II:	(a) Grossly resected tumor with microscopic residual disease. No evidence of gross residual tumor. No clinical or microscopic evidence of regional node involvement. (b) Regional disease, completely resected (regional nodes involved completely resected with no microscopic residual). (c) Regional disease with involved nodes, grossly resected, but with evidence of microscopic residual.
Group III:	Incomplete resection or biopsy with gross residual disease.
Group IV:	Metastatic disease present at onset.
MEMORIAL SLOAN-KETTERING CANCER CENTER[6]	
Stage I:	Tumor localized, completely resected, regional nodes not involved. IA — margins clearly microscopically. IB — margins not clearly microscopically.
Stage II:	Tumor extends to adjacent structures, incompletely resected, regional node not involved.
State III:	Tumor extends to adjacent structures, incompletely resected, regional nodes involved.
Stage IV:	Distant metastases present.
ST. JUDE'S CHILDREN'S RESEARCH HOSPITAL[7]	
Stage I:	Localized. Recognized tumor completely resected.
Stage II:	Regional. Adjacent structure, or local or regional lymph nodes involved; e.g. vagina + bladder, or vagina and pelvic lymph nodes: A, recognized tumor completely resectable; B, Recognized tumor non-resectable or partly resectable.
Stage III:	Generalized. A, distant metastases with normal bone marrow; B, distant metastases with bone marrow infiltration.

TABLE 2 — Alternating Chemotherapy Regimens

Vincristine	1.5 mg/m^2	Days 1 & 5	(0.9 mg)
Actinomycin D	0.015 mg/kg	Days 1-5	(0.14 mg)
Cytoxan	10 mg/kg	Days 1, 2, 3	(100 mg)
	with		
Vincristine	1.5 m/m^2	Day 1	(0.9 mg)
Adriamycin	25 mg/m^2	Days 1 & 2	(13.5 mg)
Cytoxan	10 mg/kg	Days 1, 2, 3	(100 mg)

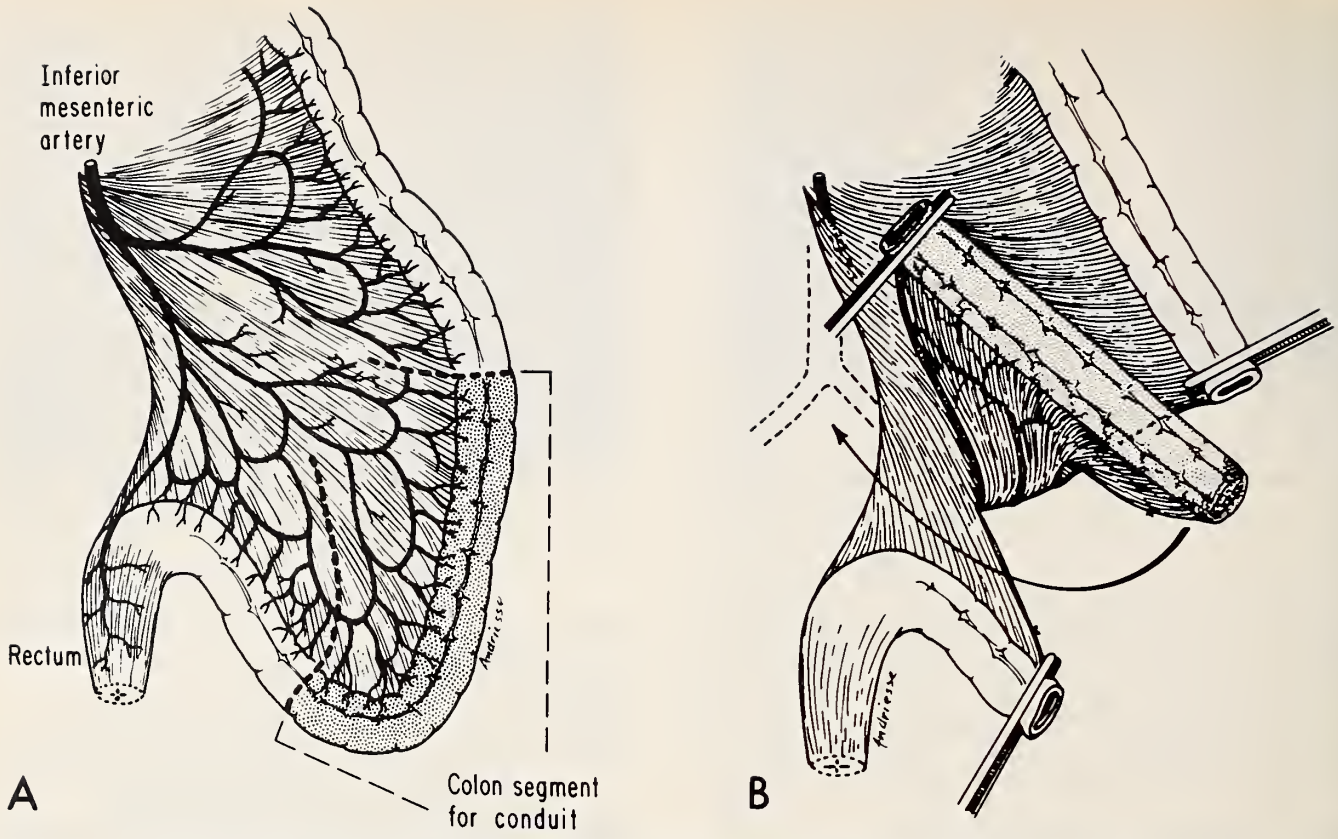


Figure 4 A — A segment of sigmoid colon is selected, with appropriate blood supply. B. The proximal end of the conduit is closed in two layers using chromic catgut sutures. The conduit is rotated 180° clockwise and is anchored at the aortic bifurcation, above the sacral promontory.

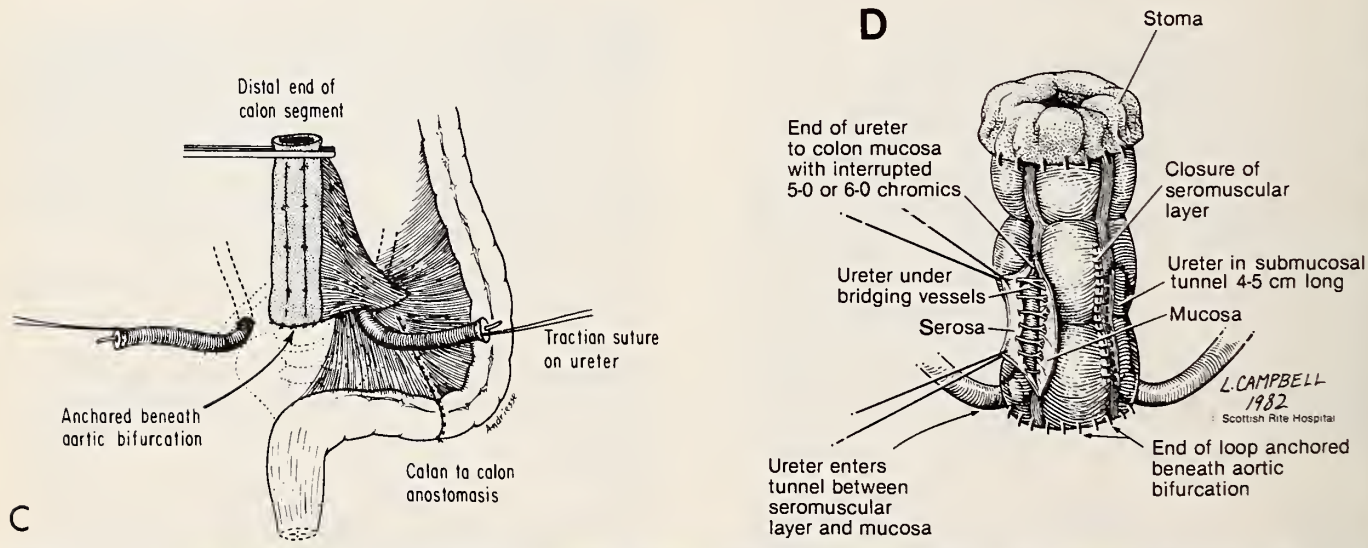


Figure 4 C — Colon continuity is reestablished, usually taking down the splenic flexure to accomplish anastomosis without tension. Mesenteric traps are closed with interrupted silk sutures. The ureters lie adjacent to the base of the conduit. In mobilizing the ureters, the periureteral adventitia is preserved to insure a good blood supply. D. Submucosal ureteral tunnels 4-5 cm long, parallel and about 2 cm apart, provide a nonrefluxing type of anastomosis.

Rare though these tumors of the urogenital tract are in childhood, simple benign polyps are rarer still.

Signs, Symptoms and Differential Diagnoses

The most common presenting sign is abnormal vaginal bleeding, which may appear alone or less frequently in association with a vaginal mass. Urinary obstruction and pain often appear late. Vaginal bleeding in the neonate is not usually considered pathologic since it represents withdrawal bleeding associated with sudden loss of maternal estrogens. Vaginal bleeding in the infant is highly suggestive of a malignant tumor. This bleeding is characterized by spots of blood on the diaper or blood appearing at the introitus following an episode of crying, coughing, or straining with a bowel movement.

Bleeding is always a serious symptom in a little girl, although not always due to a malignant lesion.

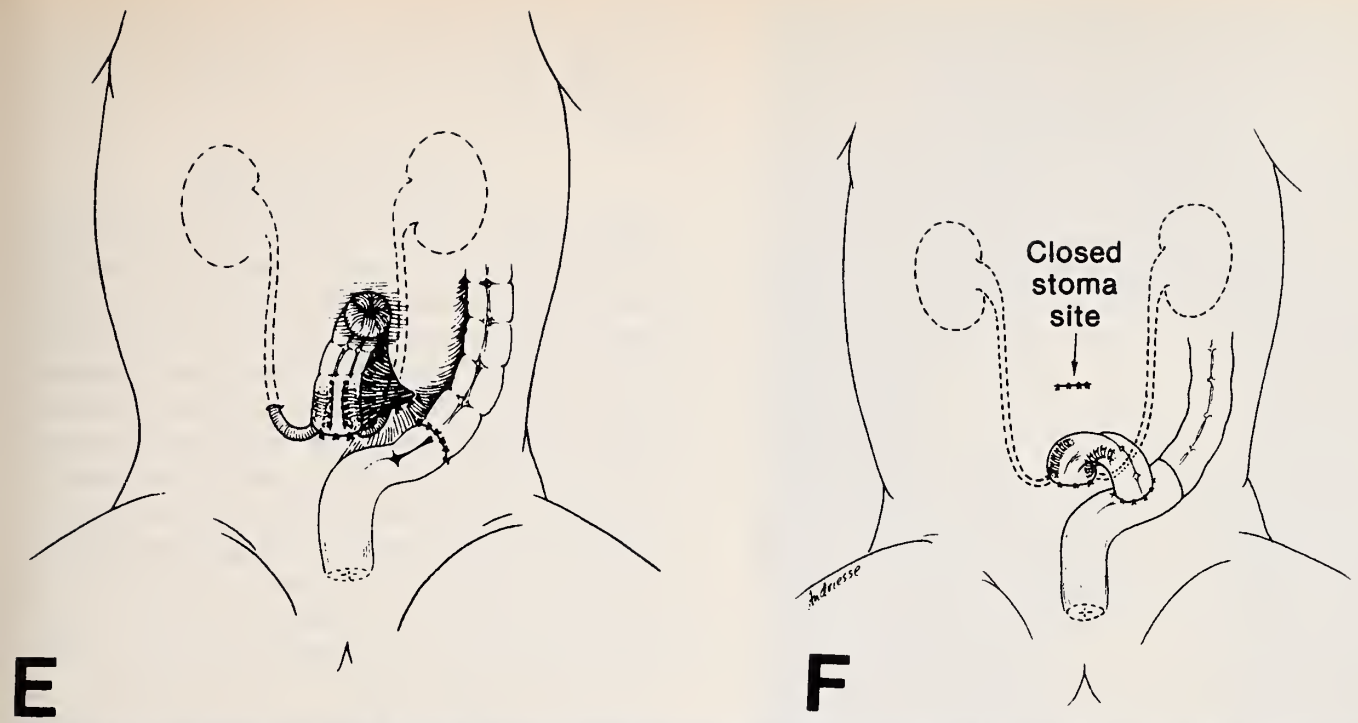


Figure 4 E — Completed conduit. F. Subsequent implantation of conduit into the colon by end-to-side technique. Appropriate only in patients with normal anal sphincter and satisfactory upper urinary tracts.

During childhood, vaginal bleeding may initially appear less serious because it is often related to trauma. Nonetheless, any vaginal bleeding occurring prior to menarche or the appearance of secondary sexual characteristics is considered pathologic until proven otherwise. Vaginal bleeding in a young child may be due to precocious puberty, a vaginal foreign body, a new growth in the vagina or cervix, or occasionally to a small number of varying lesions of the vulva such as prolapse of the urethra or scratching of the vulvar skin.

In the postmenarchal adolescent, tumor-induced vaginal bleeding may appear as menorrhagia or metrorrhagia and frequently is misdiagnosed as anovulatory bleeding. The error is further complicated by the therapeutic use of oral contraceptives, which may contribute to a delay of weeks or months before the diagnosis is made. Whenever abnormal bleeding occurs, it is imperative that investigation be undertaken immediately to confirm or refute the presence of malignancy. External examination will sometimes give a clue to the cause; if there are obvious signs of secondary sexual development in a 3-year-old, for example, it is highly likely that the vaginal bleeding has originated from this cause. If a child has had a foul-smelling, blood-tinged discharge for some weeks, a foreign body may be to blame. Unless there is clear evidence of precocious puberty as the sole cause of vaginal bleeding, examination under anesthesia is always advisable to be sure that no malignant tumor is present.

Diagnosis and Examination

Unfortunately, many of these tumors are not diagnosed at the time of onset of symptoms or at the initial examination. Because they are rare and often exhibit characteristics which appear benign, there is a tendency to erroneously diagnose them as an inflammatory polyp, urethral caruncle, vaginitis, fissure, or hymenal tag. As a result, the patient is treated by cautery, douching, or vaginal suppositories, and significant delays occur before the correct diagnosis is made and appropriate treatment is begun.

The basic failure in diagnosing these lesions occurs because the patient is not properly examined. The error most commonly is one of omission. Either the patient is not examined at all or an incomplete pelvic examination is performed. Parents, as well as physicians, hesitate and procrastinate when a child presents with a gynecologic complaint, which requires a pelvic examination for diagnosis. The tendency is to treat the bleeding as if it were due to an infection or to early menarche, with the hope that the problem will resolve itself spontaneously. Unfortunately, when the symptoms are caused by a malignant tumor they will not disappear spontaneously.

A complete pelvic examination is required in every patient, regardless of age, who presents with abnormal vaginal bleeding. A rectal examination is not sufficient. Inspection and palpation of the external and internal genitalia are required. Infants and children are the most difficult to examine, and in my experience, anesthesia is usually required for examination. Smaller instruments, including a nasal speculum or a vaginoscope, are often necessary to inspect the vagina and cervix. Gross lesions may go unrecognized if they are concealed beneath the

blades of the speculum. Palpation of the entire vaginal wall with the index finger is one means of detecting small nodules that are not clinically visible.

The adolescent can be examined in the ordinary manner, particularly if she has used tampons. A complete pelvic examination, including cervical and vaginal cytologic studies, is required. If a vaginal tumor is found, a biopsy should be done and the pelvis examined to determine the extent of the lesion and the site of origin. This may be very difficult in a small patient. The tumor mass may be so large as to almost fill the vagina, and it is difficult to decide from which point the tumor is originating. A probe, gently inserted into the vagina and swept around its walls in a circular fashion, may help identify the probable attachment of the tumor. Rectal examination is also mandatory and gives valuable information concerning the possibility of extension of the tumor posteriorly in the region of the uterosacral ligaments. Cystoscopy must never be omitted, since this gives valuable evidence of involvement or otherwise of the bladder. Other essential parts of the workup of the case include chest x-ray, bone scan, CAT scan, an intravenous pyelogram, and biochemical blood test for the evaluation of renal and hepatic function. Following this, it is worthwhile to seek consultation with an experienced pathologist and a gynecologic oncologist, who is experienced in childhood gynecologic malignancies.

Embryonal rhabdomyosarcomas of the urogenital tract grow rapidly and can cause death within 3 months after the onset of symptoms. If left untreated, most patients die within 9 to 18 months after the onset of symptoms. Without benefit of therapy, once an abdominal mass is discovered, death usually occurs within 5 to 6 months, and when inguinal lymphadenopathy appears, a survival period of no more than 3 to 4 months is expected.[2] Survival depends on the extent or stage of disease found at diagnosis and on the mode of therapy.

Staging

Several classifications have been employed for staging embryonal rhabdomyosarcomas.[4-9] The most important prognostic determinants are the extent of disease (i.e., local, regional, or disseminated), operative resectability, microscopic or gross residual disease, and/or regional lymph node involvement. The grouping schemes used by The Intergroup Rhabdomyosarcoma Study,[5] Memorial Sloan-Kettering Cancer Center,[6] and St. Jude Children's Research Hospital[7] are shown in Table 1.

Once the diagnosis has been determined, a reasonable effort should be made to establish the extent of involvement. No patient whose tumor has been treated at least once and then subsequently recurred has ever been cured of this disease.[2] This emphasizes the need for making the correct decision regarding therapy at the time the child is initially treated.

Treatment and Results

Real progress has been made in the last decade in the management of this condition. In the past, only radical surgery instituted early in the course of the disease provided any real hope of cure. In 1947, when the prognosis was still considered hopeless, Meigs (described by Ulfelder and Quan[10]) showed that this neoplasm could be treated and cured by radical pelvic surgery. A review of the literature from 1958-1971 revealed that treatment with surgery or radiation alone yielded a 9-35% survival rate,[6] but in the series reported by Hilgers et al. in 1970,[2] the survival rate increased to almost 50% after pelvic exenteration, regional lymphadenectomy, and partial or total vaginectomy. In 1967, Rutledge and Sullivan[11] reported four survivors among five children with sarcoma botryoides treated by exenteration, although followup at the time of this report was not prolonged, extending for 6 months, 2, 4, and 5 years, respectively. The need for pelvic lymphadenectomy has been substantiated by Rutledge and Sullivan,[11] who treated a large vaginal tumor in a 2-year-old girl by total pelvic exenteration, which did not include a pelvic node dissection. The patient returned 5 months later with recurrent disease in a right pelvic wall lymph node.

The question arises as to whether the need for performing as extensive and "mutilating" an operation as a pelvic exenteration on a young child is great enough to justify doing it. Rutledge and Sullivan[11] outlined the psychologic and medical preparation necessary in caring for these patients and their parents. According to Hilgers et al.[2] and Rutledge and Sullivan,[11] any treatment short of a pelvic exenteration is likely to result in failure. They contend that the minimal treatment should be an anterior exenteration and pelvic lymphadenectomy. Even if the lesion is very superficially located on the anterior vaginal wall near the urethra, this minimal involvement should not lull the surgeon into conserving the bladder at the risk of losing the patient. If the tumor arises posteriorly, or if the entire vaginal wall is involved, total pelvic exenteration should be considered. The final decision regarding the type of exenteration to be performed obviously has to be made at the time of pelvic laparotomy. However, the clinical findings established prior to operation are also important in arriving at this decision, because the site of origin of the tumor usually dictates the direction of extravaginal spread. A partial or total simple vulvectomy, preferably en bloc, should be done for low-lying vaginal lesions. Preservation of accept-

able-appearing external genitalia has been possible in my experience and this has been verified by Clatworthy.[12] Once a cure has been established and it becomes practical for the patient to have a vagina, one can be constructed surgically.

It should be safe to conserve one or both ovaries in a patient whose tumor is confined to the vagina without evidence of local extension. Characteristically, this tumor either recurs locally after treatment or metastasizes to regional lymph nodes before it metastasizes to the ovaries. The extent of involvement at the time of operation has been the most important factor regarding ultimate prognosis. Ovarian conservation does not appear to be significant in terms of recurrence of disease. I agree with Hilgers et al.[2] that the need for normal ovarian function in a prepubertal girl outweighs any prospect that the presence of the ovaries will contribute significantly to the natural course of this disease. One of the goals of cancer therapy is to preserve the quality of life without compromising survival.

Because pelvic exenteration is subject to certain limitations, more recent efforts have been directed toward increasing survival by coordinating therapeutic modalities, i.e., utilizing combinations of surgery, radiation therapy, and chemotherapy. Grosfeld, Smith, and Clatworthy,[13] for example, reported 13 cases of pelvic rhabdomyosarcoma with six survivors (46%); five of the patients were treated with a combination of radical extirpative surgery, radiation, and chemotherapy, and all survived. Ghavimi et al.[14] reported 17 survivors (63%) for periods of 18 months to 10 years out of 27 children with urogenital rhabdomyosarcoma. In their view, the combination of surgery, radiotherapy, and multiple chemotherapy offered the best chance of prolonged survival and cure. At Memorial Sloan-Kettering Cancer Center[14] and in our own current multidisciplinary protocol, patients with Stage Ia disease, in whom complete resection of tumor is performed, do not receive radiotherapy, provided that all margins of the surgical specimen are examined histologically and no evidence of microscopic disease found, but they continue to receive "prophylactic" 4-drug therapy (Vincristine, Actinomycin-D, Cyclophosphamide, and Adriamycin) for 18-24 months. Maurer et al.[5] assessed the need for postoperative local irradiation as an adjunct to chemotherapy in patients free of any known residual disease. At the time of their report, for Group I disease (localized/completely resected), disease control achieved by "VAC" (Vincristine, Actinomycin-D, and Cyclophosphamide) given in combination for 2 years had not been enhanced by the administration of postoperative radiation to the tumor bed. Ninety-two percent of patients in both irradiated and nonirradiated groups exhibited no evidence of disease, and



Figure 5 — Postoperative photograph at 4 years of age.

92-96% were still alive, with the median time of followup being 72 weeks.

The preservation of maximum function is an important aim of therapy and each modality has its own undesirable sequelae. Irradiation might be considered in place of surgery, if the morbidity of the former were less than the latter, and if, at this site, irradiation were at least as effective as radical surgery. However, the doses of irradiation required to destroy established neoplasm would lead to significant morbidity, including structural alteration of the bony pelvis due to altered bone growth, physiologic disturbance of bowel and bladder function, and possible induction of secondary neoplasms. The relatively young age of the patient with sarcoma botryoides would tend to emphasize these problems as the normal tissues of younger children are especially adversely sensitive to irradiation.

This author believes that radical surgical extirpation should continue as the initial treatment modality for localized disease. If microscopic residual disease at the resection margins is present following radical surgery, I would recommend that irradiation (4,000 rads in four weeks) be delivered to the "tumor bed" to include all tissues potentially involved by local seeding and a program of maintenance-intensive combination chemotherapy should be instituted. If gross residual disease remains after surgical extirpation, irradiation should be delivered to the site of

local tumor involvement to a dose of 6,000 rads in 6 weeks. This should be combined with an intensive program of maintenance combination chemotherapy. For patients with inoperable disease, moderate dose irradiation of 4,000 rads in 4 weeks, plus intensive chemotherapy might be administered to allow for sufficient tumor regression in an attempt at a subsequent surgical extirpation. If the latter is not possible, completion of the course of irradiation to a total dose of 6,000 rads in 6 weeks, combined with chemotherapy, may well allow for long-term survival.

Ghavimi et al.[6] reported the tumor-free survival rates for those patients with embryonal rhabodomyosarcoma treated at Memorial Sloan-Kettering Cancer Center in Stages Ia (10/10), Ib (5/5) and II (5/5) were 100%; however, these rates dropped to 67% (4/6) in Stage III. None of their three patients with Stage IV disease survived.

Between 1968 and 1975, in an effort to improve survival and to decrease morbidity of the surgical treatment, a program using preoperative combination chemotherapy followed by local radiation therapy and/or surgery was undertaken at the Children's Hospital of Los Angeles by Ortega.[15] Of the 13 children treated, only two failed to respond to initial chemotherapy, one requiring anterior pelvic exenteration with removal of the vagina, vulva, bladder, and remnants of the urogenital sinus en bloc after five courses of ''VAC'' chemotherapy. The second patient died of progressive disease after 14 months of survival. Four other deaths were observed in the group. However, three deaths occurred in patients with metastatic disease at the time of diagnosis. Another patient, Stage II at diagnosis, died after two cycles of chemotherapy of massive liver necrosis (toxicity) and autopsy failed to document any evidence of tumor. Three of these 13 patients required surgery for removal of residual disease after initial chemotherapy; one previously mentioned needed anterior exenteration and two had hysterectomy and vaginectomy.

Tefft and Jaffee[16] reviewed the literature concerning 125 cases of sarcoma of the bladder and prostate. They noted that 70% of patients with rhabdomyosarcoma of the bladder survived following total cystectomy and that no patient survived following more limited surgical resection. Furthermore, they reviewed their experience with 12 patients treated at The Massachusetts General Hospital and Children's Hospital Medical Center of Boston. Nine of the 12 patients underwent radical surgical extirpation. Seven of the nine (78%) are alive from 1-18 years from diagnosis (average 9 years). Four of these patients had chemotherapy and two had irradiation also. Three of the 12 patients had limited surgical resection. All three died of their disease after rapid, early, local recurrence.

Chemotherapy as initial treatment has been studied prospectively in Group III (localized sarcoma not treated initially by gross total resection) and Group IV (metastases present at diagnosis) patients in a cooperative effort by The Acute Leukemia Group B, Children's Cancer Study Group, and Southwest Oncology Group.[5] The patients received either intensive ''pulse'' VAC or ''pulse'' VAC plus Adriamycin, and radiation was administered after 6 weeks. Eighty-one percent of patients in Group III and 81-83% in Group IV responded favorably, with complete regression of disease having been observed in over one-fourth of patients even before the start of radiation and in approximately one-half of all the patients after receiving radiation therapy. There is no indication, as yet, that one treatment regimen is superior to the other. Seventy-nine percent of patients in Group III are still alive (0+ to 154+ weeks) and 69% remain in continuous response (0+ to 139+ weeks) with the median duration of followup being 41-44 weeks. Fifty percent of the patients in Group IV are still alive (0+ to 127+ weeks), with a median time of followup of 41-44 weeks.

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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An historical review of the genesis of guilty-but-mentally-ill laws as well as a current review of pro and con opinions from practitioners and theorists in legal and forensic fields.

Guilty But Mentally Ill — In Search of a Perspective

ILHAN M. ERMUTLU, M.D., *Atlanta**

An article printed by the *Illustrated London News* on March 11, 1843, criticized the verdict on the M'Naghten case, asserting that M'Naghten was simulating insanity and that soft-headed judges and doctors had let him escape the stern hand of justice. The talk of "profitable insanity" was widespread in the community. *The Times* also reported:

> "Ye people of England exult and be glad
> For ye're now at the will of the merciless mad . . .
> For crime is no crime — when the mind is unsettled."

Shortly thereafter, Queen Victoria requested of Sir Robert Peel, her prime minister and the intended victim of M'Naghten, that a law regulating the insanity defense be passed by the Parliament. The "rules" drawn up by the House of Lords in response to this request started an unending debate and controversy which is still with us. The debate on "not-guilty-by-reason-of-insanity" verdict will continue to occupy both the practitioners and the theorists of law.

An interesting epilogue to the M'Naghten affair, again involving Queen Victoria, occurred about 40 years later. A certain Roderick Maclean tried to assassinate the Queen by firing a pistol at her. He missed. His trial ended with a verdict of not guilty by reason of insanity. When Queen Victoria was informed about the outcome of the trial, she questioned the appropriateness of the court's conclusion on the case. Her advisors explained that the principle of English law dictated that no man can be found guilty unless he had criminal intent and that insanity negated the presence of such intent. She is reported to have said that, "If that is the law, the law must be altered," and altered it was. In 1883, the Trial of Lunatics Act (46&47 Vict.,C38) was legislated by the Parliament. It instructed that when a person was found to be insane at the time of the commission of a crime, the jury was to return a special verdict of "guilty but insane." This provision remained in the English law books until 1964 when the Criminal Procedures Act reinstituted the "not-guilty-by-reason-of-insanity" ruling in place of guilty but insane.[1] It is interesting to note that the guilty-but-insane provision was not adopted by the American judiciary until rather recently, even though English law served as the foundation of U.S. laws for a long time.

The skepticism toward the not-guilty-by-reason-of-insanity ruling has kept the debate alive through the years. An affinity to sensationalism on the part of the news media, which gave special prominence to certain bizarre and senseless crimes committed by the mentally ill, heightened consciousness of the public in such cases, causing frustration in the community when the perpetrator was sent to a mental hospital instead of to prison.

Since the days of Judge Bazelon of the District of Columbia, the changes in the legal formulation of insanity, which aimed to modernize the laws dealing with the mentally ill offender, seem to have provoked more resentment and distrust in the public. Moving away from the somewhat concrete standards of the M'Naghten rule and establishing the kind of standards of insanity which gave recognition to less tangible aspects of human psychology in the courtroom added more fuel to the argument against not

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guilty by reason of insanity verdicts. The battle of psychiatrists as expert witnesses defending opposing views added to the confusion. But the most significant factor which led to enactment of the guilty-but-mentally-ill provision was court decisions during the past few years dealing with the substantive and procedural rights of mentally ill persons.

The most obvious and direct motivation for the first GBMI legislation enacted in this country was the 1974 Michigan Supreme Court decision in *People v. McQuillan* which attacked the automatic commitment statutes providing for indefinite incarceration of individuals found not guilty by reason of insanity.[2] Such statutes have come under severe criticism, because they did not offer equal protection and due process for individuals. There was no provision for a hearing to determine whether the person who was declared not guilty by reason of insanity was mentally ill at the time. Before such court rulings, most American jurisdictions had followed the lead of Britain's Lunatics Act and justified assuming custody of such persons under the parens patriae doctrine.

The most significant factor which led to enactment of the guilty-but-mentally-ill provision was court decisions during the past few years dealing with the substantive and procedural rights of mentally ill persons.

Following the McQuillan decision, 64 inmates were released from Michigan institutions, because they did not meet the standards for civil commitment. Two of these inmates were involved in violent crimes after their release. One of them, John McGee, kicked his wife to death about a month after his release. Another ex-inmate, Ronald Manlen, raped two women shortly after gaining his freedom. The public reaction to these incidents forced the Michigan legislature to pass a new law creating a guilty-but-mentally-ill (GBMI) provision in 1975.[3]

A similar situation led to the enactment of Georgia's GBMI legislation in 1982. A federal district court decision in *Benham, et al. v. Edwards* class action suit struck out certain provisions of Georgia statutes dealing with the persons declared not guilty by reason of insanity. Up to that point, following the NGRI verdict, the person who was sent to a mental institution could petition for discharge after 30 days of confinement. The court had to hold a hearing on the case to decide on a disposition. If the court ruled against the release of the individual, no further hearing could be scheduled for the next 12 months. The Benham decision eliminated the 12-month waiting period and instituted a hearing after 30 days of confinement to determine if the mental state of the person met the standards for involuntary hospitalization provisions of the Georgia laws. If the standards were not met, the person had to be discharged from the mental hospital. Shortly after the Benham decision, a person who was previously declared not guilty by reason of insanity committed a triple murder 6 months after his release from the state hospital in Savannah. The incident added to the expressed frustration of the judiciary caused by the Benham decision and was widely publicized by the media. The following year, Georgia joined the ranks of the states which legislated guilty but mentally ill laws.

Presently, Alaska, Delaware, Georgia, Illinois, Indiana, Kentucky, Michigan, Pennsylvania, and New Mexico have included GBMI provision in their statutes. The following states are considering similar legislation: Arkansas, Florida, Maine, Massachusettes, New Jersey, North Carolina, Ohio, Rhode Island, South Carolina, Texas and Virginia.[4]

It is interesting to note that GBMI provision was seen as a remedy to the perceived problems of NGRI provision. The passage of GBMI legislation was supposed to eliminate such problems. Attempts to abolish the insanity defense in the past were unsuccessful due to the decisions of state supreme courts in Washington, Louisiana, and Mississippi some years ago. The United States Supreme Court has not ruled on whether the insanity defense was constitutionally required. Recently, Alabama, Montana, and Idaho enacted laws that significantly modified the use of the insanity defense in these states. In fact, mental illness is no longer a defense issue in these states. Future challenges to these provisions are certainly expected.

The provisions of GBMI statutes in all states are reasonably uniform. To apply the GBMI verdict, three issues must be established: (1) guilt, (2) presence of mental illness at the time of the crime, and (3) absence of legal insanity. Usually the issue of mental illness is brought to the courtroom in the form of insanity defense in its traditional form as a plea of not guilty by reason of insanity. After the review of evidence, the judge instructs the jury to consider not-guilty-by-reason-of-insanity and guilty-but-mentally-ill verdicts along with conclusions regarding guilt. The related Georgia statute declares:

> "Whenever a defendant found guilty but mentally ill at the time of a felony, or enters a plea to that effect that is accepted by the court, the court shall sentence him in the same manner as a defendant found guilty of the offense. If a defendant who is found guilty but mentally ill at the time of the felony is committed to an appropriate penal facility, he shall be further evaluated and then treated, within the limits of

state funds appropriated therefore, in such manner as is psychiatrically indicated for his mental illness."

In Georgia, the inmate is transferred to a mental hospital if his condition requires more intense treatment than is available at the prison system. Some states require determination of current mental status in a mental health facility before the individual is placed in the correctional institution.

Contrary to expectations, the impact of the GBMI provision on the NGRI issue has been minimal. In Michigan, implementation of the GBMI provision resulted in a temporary decline in NGRI findings after which NGRI verdicts returned to their earlier levels. A survey of other states with GBMI statutes resulted in similar findings.

Present Georgia statutes require that the defendant who is given a guilty-but-mentally-ill verdict must be placed in a facility of the Department of Offender Rehabilitation.

During the first 6 months following GBMI legislation, which went into effect on July 1, 1982, there were 13 cases of GBMI verdicts in Georgia. Only one of these patients had to be hospitalized in a mental health facility. The information obtained from the Department of Offender Rehabilitation indicated that many of the defendants were mentally retarded and others entered the GBMI plea as part of plea bargaining. Very few of the defendants had adequate psychiatric evaluation at the time of court proceedings. The application of GBMI provision without an evaluation of the defendant's mental condition raises serious questions about the manner of implementation of the law.

Another issue which confronts the courts in the implementation of GBMI provision is where to send the individual who receives this verdict. Should the person be sent to a mental hospital or be immediately confined in a correctional facility? The determining factor must be the current mental status of the person in question. During the trial, the focus is on the mental condition at the time of the offense. By the time the trial is concluded, an average of 6 to 8 months have elapsed from the time of the incident. Excluding severe mental retardation and advanced, irreversible organic brain syndromes, it is reasonable to assume that certain changes will occur in the person's mental condition within that period. Because of the availability of mental health services in many areas, it is likely that the defendant with a major psychiatric disorder will receive some treatment, including psychotropic drugs, during the period from the time of arrest and end of the trial. Mental health authorities are generally reluctant to establish a procedure by which all GBMI verdict recipients are automatically committed to state institutions for an evaluation due to the costly nature of this proposition. Nevertheless, different states have established varying procedures to deal with this issue. In Michigan, all defendants who plead GBMI are first evaluated by the forensic center in Ypsilanti, and a report is given to the court on the need for treatment. The more common practice is first to send the individual to the prison, and if it is determined at a certain point that treatment in a mental health facility is necessary, then to transfer the individual to the state hospital according to the procedures agreed upon by the mental health and offender rehabilitation agencies. Indiana resolved this issue in a unique manner by transferring an entire 600-bed psychiatric hospital to the Department of Corrections.

Generally, time spent in a mental hospital for treatment following GBMI verdict is applied to the sentence. In Michigan, the parole board receives reports on such cases and continued treatment may be made a condition of parole. If the defendant must be kept in a mental hospital after the end of his sentence, a civil hearing must be held to determine whether the current mental condition meets the test of involuntary admission.

Present Georgia statutes require that the defendant who is given a GBMI verdict must be placed in a facility of the Department of Offender Rehabilitation. If the subsequent psychiatric evaluation indicates the need for hospitalization for the treatment of a major mental disorder, he/she is transferred to the Forensic Division of Central State Hospital. Since many of the GBMI inmates have no current mental status evaluations, offender rehabilitation officials, who have only limited resources to secure quick psychiatric opinions in these cases, have found themselves in an uncomfortable and potentially liable position. The fact that the new GBMI statutes do not provide for the court to send the defendant directly to a mental health facility further complicates the situation. Even though the Georgia prison system has some treatment and rehabilitation capability for certain types of mental disabilities, it has serious limitations in dealing with the severely disabled and in providing quick and comprehensive evaluations.

The GBMI issue created its own controversy while trying to remedy the frustrations caused by the traditional insanity defense.

In addition to some of the questions regarding the implementation of GBMI provisions, it is ironic that the GBMI issue created its own controversy while trying to remedy the frustrations caused by the tradi-

tional insanity defense. The legislation of GBMI laws drew pro and con comments from the practitioners and the theorists in legal and forensic fields. A brief review of opinions from both sides of the aisle would help to gain a better perspective on this subject.

Supporters of GBMI legislation assert that one of the most significant aspects of the provision is to insure that convicted persons who are in need of psychiatric treatment will receive it.[5] Observations indicate that in the past, mentally ill offenders in the criminal justice system were largely ignored until their behavior became grossly disturbed, making it impossible for them to remain in the prison community. Also, the GBMI provision, at least in Michigan, permits the prosecutor to offer probation up to 5 years with the condition that the person will submit to psychiatric treatment during that period.

Supporters of GBMI legislation assert that one of its most significant aspects is to insure that convicted persons who are in need of psychiatric treatment will receive it.

There is also the belief that the presence of the GBMI statute will discourage frivolous use of insanity defense. It is generally accepted that GBMI statutes will pass constitutional tests.

The critics of GBMI laws claim that the degree of criminal culpability required for a GBMI verdict is the same for the usual guilty verdict and the "but mentally ill" portion merely duplicates existing statutes regarding the right of convicted persons for mental health services.[6] A frequently expressed concern, however, is that such services in correctional systems are inadequate. The most common criticism is the assertion that the GBMI statute will result in erosion of the insanity defense and will deny future defendants due process as a result. One potential problem is the possibility of confusion on the part of the jury, especially in states where the definitions of insanity and mental illness are close. This may be a valid question if the A.L.I. definition of insanity is used. The definitions quoted below may illustrate the point:

> 1. Insanity: as a result of mental illness . . . that person lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law.
>
> 2. Mental Illness: a substantial disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

The concern is that the confusion stemming from the overlap between the statutory definitions of mental illness and legal insanity and the tendency of jurors to compromise are certain to cause some legally insane defendants to lose not only their statutory rights but also their constitutional right to acquittal.

However, a review of 57 GBMI cases in Michigan indicated that only two of these cases might have won NGRI designation. The availability of GBMI ruling did not appear to reduce NGRI verdicts.[7]

Another question raised is that a GBMI verdict forces the offender to undergo involuntary psychiatric treatment without due process.[8] Automatic commitment to therapy only on the basis of mental illness at the time of offense is not seen as being sufficient, and the need for a current evaluation before such commitment is emphasized. The *Vitek v. Jones* (1980) ruling of the U.S. Supreme Court is mentioned in this context.

Some experts interpret the move toward GBMI laws as a conflict with mens rea principle. The validity of such interpretation may be questioned, because in almost every state where GBMI statutes have been legislated, insanity defense is still available.

The American Psychiatric Association's recently issued statement on insanity defense also expresses a certain amount of skepticism on the subject of GBMI and points out that "the guilty but mentally ill plea may cause important moral, legal, psychiatric, and pragmatic problems posed by the insanity defense to receive a whitewash without fundamental progress being made."[9]

Among the more positive results of the GBMI legislation is its impact on mental health services in the criminal justice system.

In conclusion, the impact of the guilty-but-mentally-ill provision on the mental health system appears to be not significant. It is obvious that it will not resolve the issues relating to the not-guilty-by-reason-of-insanity statutes. The debate regarding the role of psychiatry in the courtroom will also continue for a long time to come. The GBMI provision is not expected to be very popular with the trial lawyers. It probably will be a factor in plea bargaining.

Among the more positive results of the GBMI legislation is its impact on mental health services in the criminal justice system. The correctional systems find themselves in a precarious position when a convict with the label of "mental illness" is received in the prison. The system now feels an obligation to meet the needs of the individual and seeks

more assistance from the mental health system. Increased cooperation and a closer working relationship between these two systems will be facilitated by the GBMI legislation.

It is difficult to argue against the notion that the GBMI laws were responses to public sentiment provoked by certain sensational cases which received wide publicity. The juries are provided with an alternative in some difficult situations when public conscience demands punishment but at the same time a merciful action is called for to deal with the mental problems of the individual. Time will show if such a measure is the answer to the issues raised by the public on the subject.

At this time, it is fair to say that "the jury is still out" on the GBMI issue.

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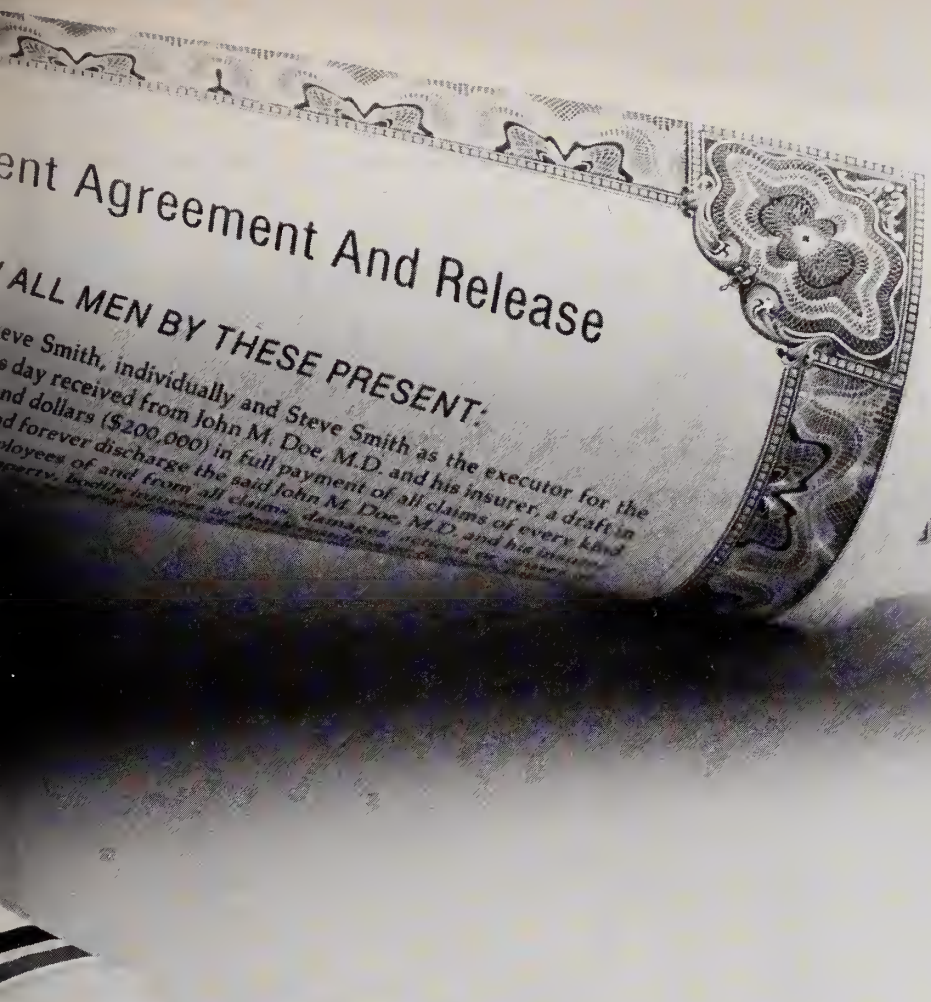


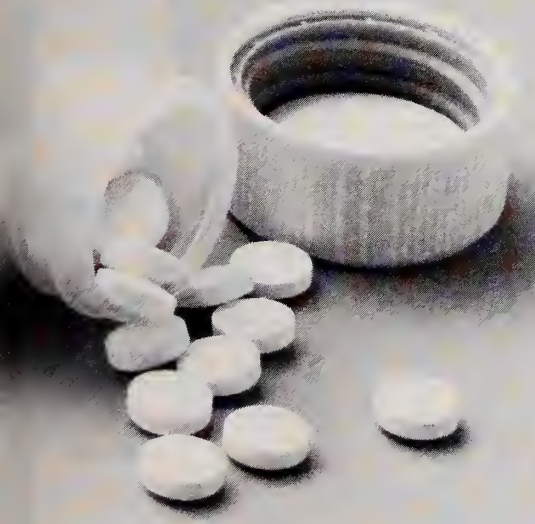
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Georgia's Poet Laureate — A Man For All Seasons

EVELYN WARD GAY, ***Decatur****

I thought to be a poet.
I felt I had his eye and ear,
If not his words;
I knew I had his heart.

THOSE WORDS were written many years ago by Dr. John Ransom Lewis, Jr. Today, as Georgia's poet laureate, the Atlanta plastic surgeon is recognized as an accomplished poet whose words are read and enjoyed by people of all ages.

Yet as much as he likes to express his thoughts in words of his own, Dr. Lewis is a modest and thoughtful man who believes in promoting the works of others. Revealing this characteristic of his nature was his response to the invitation to become his state's poet laureate some 10 years ago.

When Georgia's governor paid him a visit and later made his intention known, Dr. Lewis replied that he would not have enough time to give to the post the attention it deserved, but he would be happy to furnish a list of people he felt would be more capable of filling the post. On Christmas Eve, he received a call from the governor, telling him that his family had read the poems of other people but still wanted him to accept the honor.

"If he wanted me that much," says Dr. Lewis, "I felt that I could find the time."

And find it he did. Every Friday is "poetry day" in his life. He sets aside that one day each week to visit with school children to help them read and enjoy poetry and learn to compose their own verses.

He averages 50 talks a year to students from kindergarten to college. He also travels occasionally to other states to read poetry. In November of 1981, he participated in a program at Shenandoah College near Washington, D. C.



John Ransom Lewis, Jr., M.D.

He often goes to mental hospitals to read poetry to the patients. Afterwards, he has been told that his appearance has been good for emotionally disturbed people and sometimes brings out those withdrawn people who cannot be reached in any other way.

He conducts study sessions for the Atlanta Writers Club, for which he has served as president, and has been a dinner speaker several times for the Dixie

* Mrs. Gay is a member of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.

Council of Authors and Journalists. A special collection of books by Georgia authors, including photos and letters, paintings and sculpture, was given recently in his honor to the library at Emory College at Oxford.

Poets Laureate Background

The original English poets laureate were appointed to commemorate events in history, such as battles, victories, or other memorable happenings. These poets were named for life by an English sovereign and were considered to be members of the royal household. Usually, they were chosen because of their reputation as the country's most eminent and celebrated composers of rhymes.

The custom in the United States dates back only to the mid-1920s, says Dr. Lewis, and only 17 states have poets laureate. There is no national poet laureate, and Dr. Lewis is the seventh person to hold the post in Georgia. All except one of them have been men.

Appointment to this honor is made by the governor of a state with the approval of the legislature. And each poet laureate sets up his own rules. Dr. Lewis decided early that there would be two important elements of his plan to carry out his duties: 1) to interest young people by helping them enjoy and have fun reading and writing poetry and continue to learn from it; and 2) to promote and publicize Georgia writers in general. He tells his audiences that there are many books written by Georgia authors which are worthy of being read.

Dr. Lewis likes to talk about poetry writing. He tailors his system of instruction to the ages of his students. The words of poetry are important, he says, and he believes that everyone should learn first the technique of writing traditional poetry. But even free verse has a rhythm, he declares, and he agrees with Robert Frost that "writing poetry is like playing tennis with the net down."

Dr. Lewis himself writes all types of poetry, from whimsical to serious. When asked to write a poem for the library at Epworth-By-The-Sea, he composed one called "The Marshes" and dedicated it to "Sidney Lanier, an Ecologist Before His Time."

Georgia's poet laureate has several favorite poets and many favorite poems. He likes best Robert Louis Stevenson's "A Child's Garden of Verse." Robert Browning runs a close second in his estimation, and the American poet whose work he especially enjoys is Robert W. Service. Other favorite writers are Robert Frost and Winston Churchill.

Of his own poems, he has two favorites. They were written from his experiences while serving in the Navy in the South Pacific during World War II. While he claims that he does not write much religious poetry, both show such a flavor.

Kamikaze

I'm numbered among the dead.
Perhaps I tried too hard to live.
Seeing the Kamikaze,
I raced below to seek a safer spot,
Arriving just in time to meet the enemy.
And his plane,
Amidships opposite the magazine. —
I'm of the ocean now, of its blue brine,
A part of all its calm and turbulence. —
This marker is in memory
Of me —
Nothing is hotter than a burning ship!
Why should I ever worry
About Hell!

The Place of a Gem

The sea is a diamond
Flashing its borrowed fire
Back to the sun and stars,
Buffed of its grime of clouds and fogs and mists
By the cleansing rain
And polishing cloth of winds, —

Cool as the blue of its crystalline depths
And warm as the fire its facets flash,
The sea is a diamond,
Fixed in the setting of the earth, —
One stone in the necklace
Of the universe,
Hanging about the neck
Of God.

Dr. Lewis has had two books of his poems published. The first, *To Dock at Stars,* came out in 1962. The second, *Small Town and Other American Poems,* was published in 1976. His poems also have appeared in a dozen anthologies of Southern literature. Currently, he is preparing for publication an anthology of the works of other Georgia poets.

Dr. Lewis has no problem explaining the close relationship which he sees between poetry and plastic surgery. Both are forms of art. Doctors are creative people, he says, and among plastic surgeons are many artists, sculptors, and musicians. Plastic surgery itself is very creative, and a knowledge of art is a necessity in reconstructive surgery.

But poets are idealists, he avers, and writing poetry is an escape. He has enjoyed reading and writing poems for as long as he can remember.

Personal Background

The Lewis family was a mainstay in the small southeastern Georgia town of Louisville, the state's former capital, where Johnny Lewis grew up as the only son of a physician. At an early age, he knew he wanted to be a poet, and his first poem was published in his school newspaper. He also wanted to be a doctor.



Dr. Lewis visits with students in a Marietta school and teaches them about poetry.

These two ambitions, however, were not his only ones. Athletics found a place in his life, and he played high school football and baseball, sports which led to offers of contracts to play Major League baseball when he entered college. But for a time at least, his love for medicine won out over his desire to play ball, and he buckled down to his studies at Emory at Oxford. Later, he completed his premedical training at Emory University in Atlanta. While at both schools, another of his talents came through.

As a child, his mother had wanted him to take music lessons, but he had thought that was something only a sissy did. So he had agreed only to beat his drums to her piano accompaniment. In college, however, he became a member of the glee club at Oxford and at Emory to satisfy his love for music.

He was awarded his B.S. degree in 1938 from Emory University after completing his first year in the Emory University School of Medicine, and was graduated with an M.D. degree from the latter in 1941. He also had been named to membership in Phi Beta Kappa and Alpha Omega Alpha.

After 4 years of general surgery at Grady Memorial Hospital in Atlanta, he entered the Navy for a 2-year tour of duty in the South Pacific, first at Pearl Harbor and later at other stations in the area. While on military duty, he found time to write some poetry. He also played semi-pro baseball.

Returning to Georgia following the war, Dr. Lewis spent one year practicing general surgery in Canton but decided quickly that he wanted a different kind of life. He went to the Straith Clinic in Detroit where he became proficient in plastic surgery. Since that time, he has been in the practice of his specialty in Atlanta. He is the author of several textbooks in his field, including *The Surgery of Scars, Atlas of Aesthetic Plastic Surgery,* and *Textbook of Plastic Surgery*. He edited a 2-volume work on *Aesthetic Plastic Surgery* and has written chapters in a number of other textbooks, including one to be published in England this fall. He has lectured in many parts of the United States, as well as throughout Europe, Asia, and South America, and the state of Hawaii. On an extended lecture tour in 1981, he spoke in Athens, Greece, to the European Confederation of Plastic Surgeons, and in Cairo, Egypt, to the International Society of Aesthetic Plastic Surgeons.

Dr. Lewis usually puts in a full 12-hour day at his practice. He is up by 6 a.m., and arrives at the hospital by 7 a.m. For 5 or 6 hours, Monday through Thursday, he is in the operating room, and then he sees patients in the evenings. He has earned a reputation among friends, patients, and colleagues of never seeming too tired to give his attention to anyone who shows a need for it.

Dr. Lewis has five children, one of whom, a son at Emory University, has aspirations of being a physician. His wife, Chris, who is from Port Huron, Michigan, shares her husband's love of the arts. Her special touch is evident in all areas of his suite of offices, but especially on one wall where he displays prominently his membership certificate in The American Society for Aesthetic Plastic Surgery. About 15 years ago, he explains, she submitted the winning design for the striking red logo which adorns the certificate.

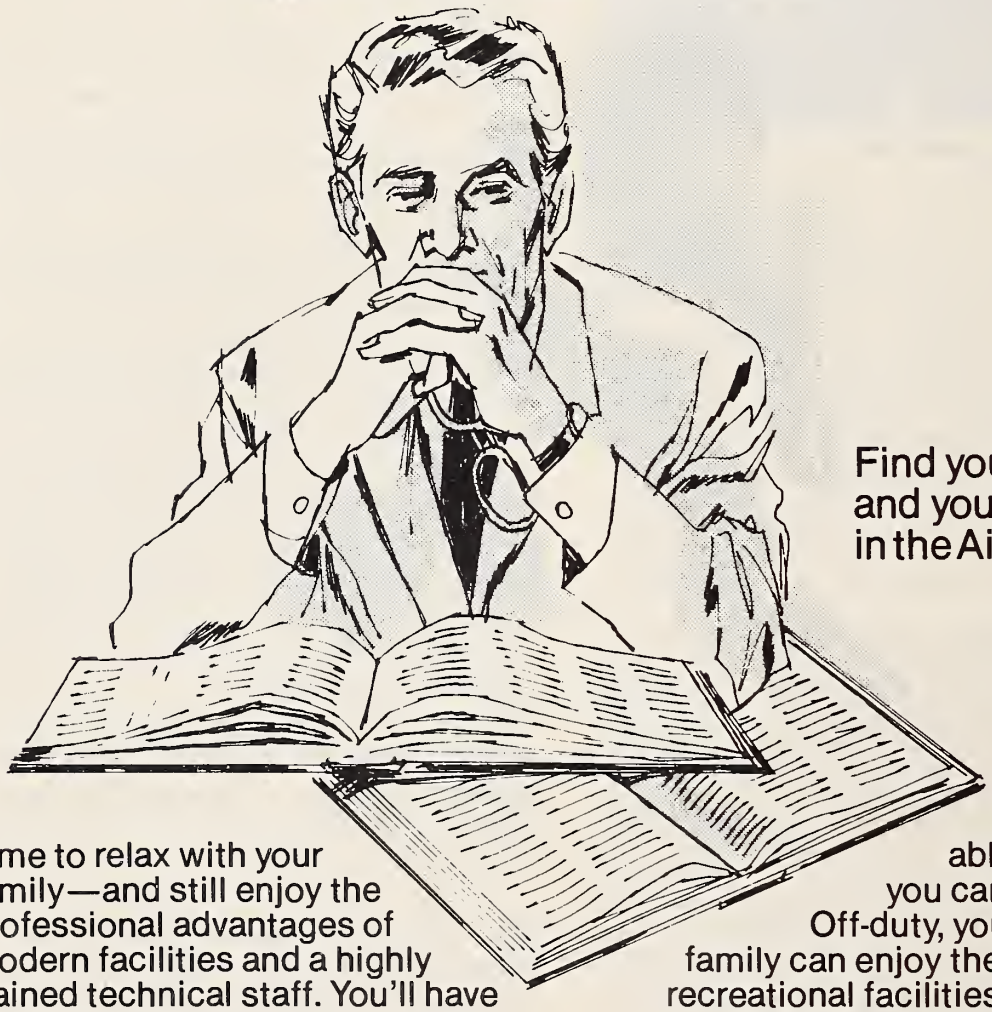
Almost everyone who is asked to point out his favorite poem among those written by Dr. John Ransom Lewis, Jr., will cite the title poem in his first book of published poetry.

To Dock at Stars

If I could use my wasted years once more,
How slow, how sweet, would be the gentle hours
With you! Waves that climb the silent shore
Of night to touch the gray cathedral towers
Of dawn must seek for treasures they attain;
And so must I for keys that lock the past
In velvet vaults of memory in vain.
A hope still sails with ever-swaying mast
And billowed sail across the evening sky
Of time. When waves have stopped to taste the sands,
And dreams have docked at stars, shall I ask why
The anchor drop sends ripples from my hands
To shores that rim the silver seas of sleep?
How bright, how real, the memories I keep!

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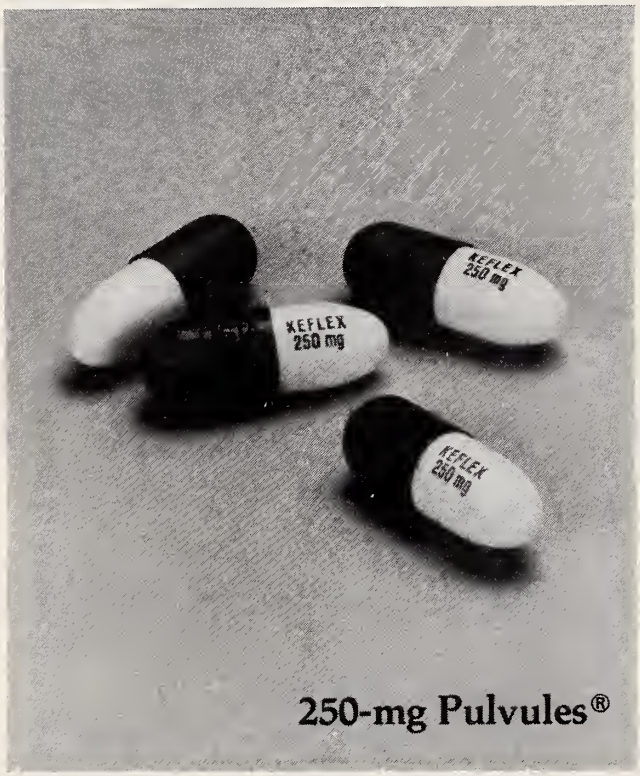
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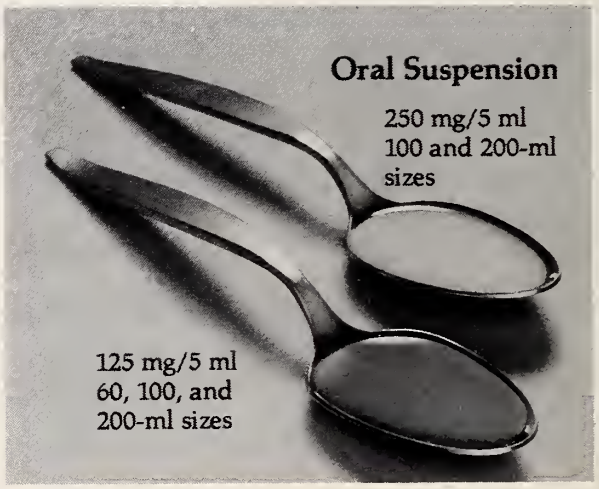
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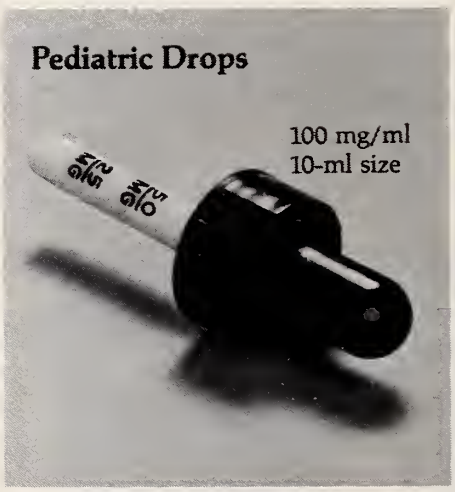
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TEFRA — What's It To You?

DRAMATIC changes in the way the federal government will pay for health care were heralded on September 3, 1982, by Congress' enactment of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA). This was promptly signed into law by President Reagan and is being implemented with remarkably little fanfare. This legislation was developed by the federal government in response to the relentless increase in the cost of health care which began in 1965.

The Cost of Medicare

The Medicare program was passed by Congress in 1965, with the major goal of the program being to improve access to health care for the elderly. This program offered the elderly a comprehensive package of benefits with little cost sharing. Hospitals were paid "reasonable cost" and physicians were paid "usual, customary, and reasonable fees." These payment procedures encouraged utilization by the elderly. Admissions of patients over 65 doubled from 1965 to 1980 and accounted for 60% of the total increase in admissions.

Because of increased demand for services, the total outlay of Medicare and Medicaid dollars for 1983 will be 12 times that spent for these two programs in 1966, their first year of operation. In 1982, $64 billion was spent on federal Medicare and Medicaid, in comparison to $9.9 billion in 1970. In 1984, it is estimated that these two programs will cover 52 million people, with 30 million elderly and disabled being covered by Medicare, and 22 million poor being covered by Medicaid.

The Genesis of TEFRA

The high cost of health care is perceived by physicians, hospitals, their patients, and third party payers to be the single most important problem in health care today. The American Medical Association's "National Commission on The Cost of Medical Care" developed over 40 recommendations to attack this problem. One recommendation advised a *trial* of prospective payments to hospitals as a means of introducing *incentives* for the more economical delivery of health care. This was approved by the American Medical Association's House of Delegates in 1978.

The American Hospital Association also began consideration of a prospective payment system at the same time. Their goal also was to change *incentives* in the health care system with as little disruption of quality and access as possible. It was projected that if fiscal resources were to be limited, physicians and hospitals would *have* to make the critical decisions to preserve health care. The American Hospital Association's House of Delegates approved such a system in 1982 and as reported above, Congress passed this legislation a short time later.

This legislation has diverse ramifications including a change in pension regulations which reduces the maximum contribution a corporation can make to your pension plan. Changes were made in the payment of hospital-based physicians as well as freezing medical payments for other physicians. Changes were made in

payment mechanisms for Medicaid hospital patients, and the Department of Health and Human Services (formerly DHEW) was directed to return to Congress with a specific plan for prospective payments to hospitals for Medicare inpatient care. On December 28, 1982, the basis for this legislation was presented by the Department of Health and Human Services, which, if approved by Congress, would pay hospitals a *single global* amount of money for each hospitalized Medicare patient. The amount of money would be based on the diagnosis and not on the services provided or the length of stay.

A hospital administrator's nightmare and an accountant's dream, the net effect of section 101 of the TEFRA legislation is to reduce payments made for Medicare recipients.

The concepts of TEFRA (retrospective) payment and prospective payment were combined in the House Ways and Means Committee Action of March 3, 1983.

Section 101 of TEFRA outlines the method for reimbursing hospitals on a per case basis for Medicare patients on a retrospective basis. Section 223 limits were expanded to include all costs of inpatient routine care including routine care, ancillary services, and special care. The following are "pass-throughs" in addition to the 223 limit: outpatient costs, capital costs, medical education, malpractice insurance, and Medicare bad debts.

Limits are on the average cost-per-case basis adjusted for case mix. Limits will be set at 120% of the mean in fiscal year 1983, 115% in fiscal year 1984, and 110% in fiscal year 1985.

In addition to the limit, each hospital will have a target rate per case based on the prior year's allowable costs per discharge. In the first year, the target rate will equal the prior year's cost increased to the forecast "market basket" plus 1% for intensity. The market basket increase for 1983 is 7.9% and 8.6% for 1984. The target rate for the second year equals the target rate for the first year plus 8.6%.

Under the wording approved by the House Ways and Means Committee on March 3, 1983, a combined TEFRA (retrospective) rate and prospective rate would be used to pay hospitals for each Medicare patient based on *diagnosis related groups* (DRG). Under this system, separate urban and rural DRG rates would be established for each of the nine U.S. Census regions. Thus, there would be 18 separate DRG rate schedules used in the first 3 years of the program. For the fourth year of the program, there would be two rate schedules, one urban and one rural. This 4-year hybrid system would work as follows:

Accounting year beginning on or after	*TEFRA**	*Prospective Rate†*	*Number of Rate Schedules*
October 1, 1983	75%	25%	18
October 1, 1984	50%	50%	18
October 1, 1985	25%	75%	18
October 1, 1986	0	100%	2

* Retrospective rate based on 100% of mean cost per discharge.
† Based on individual rates per DRG.

The phase-in of the prospective rate system is intended to allow each individual hospital to adjust to the new form of reimbursement. The new hybrid system is supposed to be TEFRA neutral for each census region.

TEFRA's Effect On Hospitals and Physicians

The net effect of section 101 of the TEFRA legislation is to reduce payments made for Medicare recipients. It is a hospital administrator's nightmare and an accountant's dream. Medical record librarians face definite challenges in classifying and coding services rendered. To the physician, it represents a threat to the private practice of medicine because it focuses on "cookbook medicine" and forces individual physicians to change their individual practice patterns to fit the prescribed pattern of practice.

For hospitals to survive under a prospective payment system, definitive action must be taken to accurately document the work performed. We need better data collection and a better analysis of the resultant case mix documented by that data. Medical records information must be complete and accurate if the hospital is to be paid for the services rendered. Many hospitals must combine their medical records information systems with their financial systems so that the hospital can have a DRG cost-reporting system. Through better data collection and data management, individual medical staff members can be provided with information about their patients that will enable each physician to more effectively and efficiently utilize hospital resources.

Medical staff utilization review committees will be asked to assist with the management of case mix by reviewing practice patterns of physicians treating the same diagnosis. Physicians will be asked to use pre-admission testing, scheduling of services, and more discharge planning.

Hopefully, the medical staff will assist the hospital administration in case mix management by being more involved in the monitoring of utilization of services. In the future, the cost of treating and the reimbursement allowed for *each* DRG must be developed. Some hospitals will probably curtail the treatment of DRGs that are money losers and will seek to promote DRGs that are money makers.

Conclusion

The concept of tying reimbursement to DRGs is here to stay. The DRG system is the best system currently available to measure case mix and intensity. As a result, hospitals and medical staffs must do everything practical to effectively and efficiently monitor and manage case mix.

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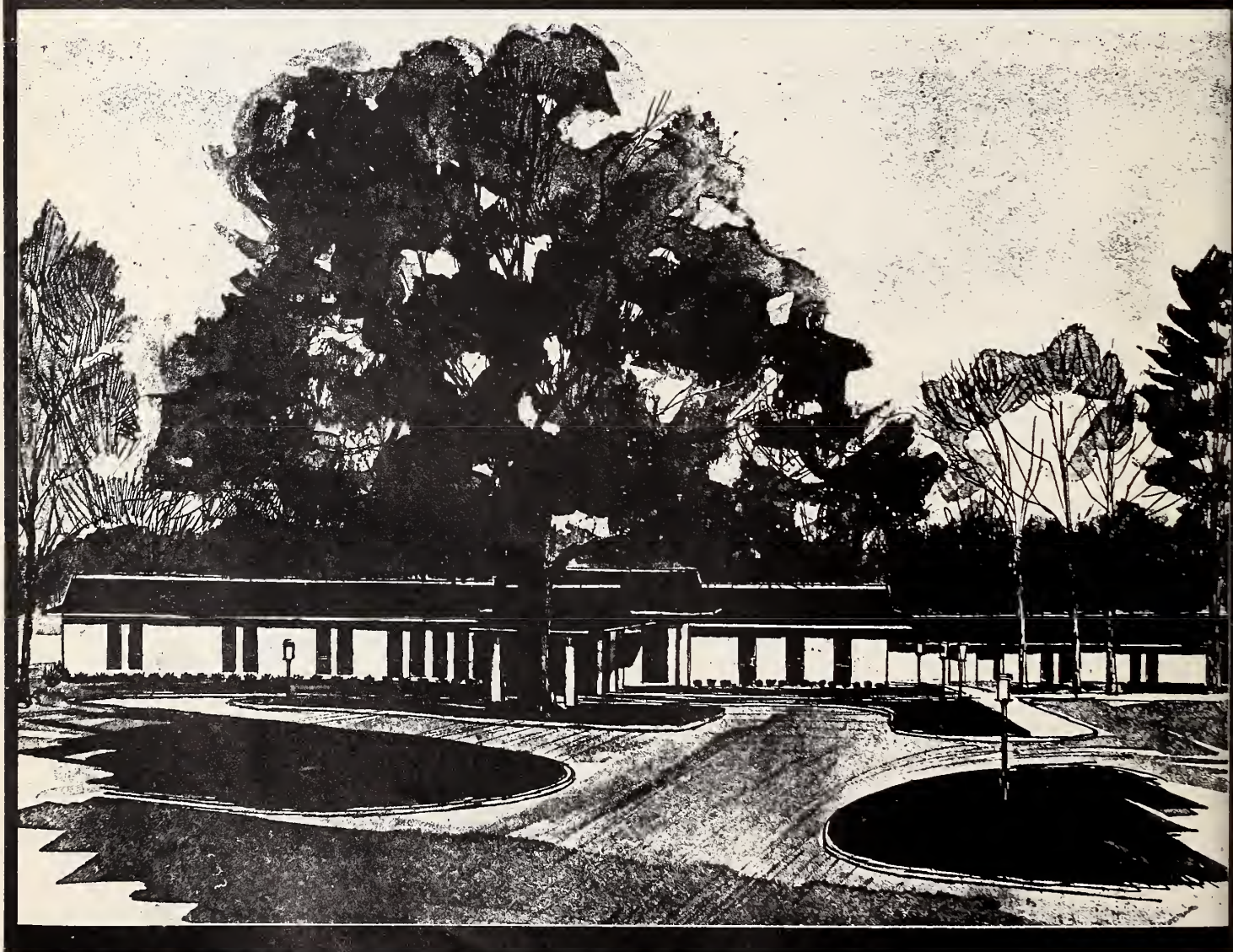
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Mild Hypertension

ALBERT A. CARR, M.D., *Augusta**

PROSPECTIVE DATA are available to determine when to prescribe chemotherapy to prevent complications of high blood pressure (HBP). When to prescribe becomes less clear as the diastolic blood pressure (DBP) approaches 90 mm Hg. HBP associated with retinal infarctions and or papilledema reduces life span. Those patients without retinal infarctions or papilledema and DBP between 90-130 mm Hg are different with regard to the benefit-risk of chemotherapy used to prevent complications of HBP. The results of several clinical trials are reviewed and interpreted here.

Veterans Administration Cooperative Study Group on Antihypertensive Agents[1-3]

Selection: Hospitalized male patients with essential hypertension, DBP 90-129 mm Hg, were included. Then, on an ambulatory basis, they were selected to take either placebo or fixed chemotherapy if they were reliable and their DBP remained between 90-129 mm Hg after several visits and measurements. These patients were stable. Some already had cardiovascular-renal complications. Chemotherapy reduced hypertensive complications or morbidity and mortality when entry DBP was greater than 104 mm Hg. No benefit was documented when DBP was 90-104 mm Hg unless patients were over age 50 or there was pre-existing cardiovascular-renal complications. These complications or "target organ" involvement represent the following: marked retinal arteriolar narrowing or flame shaped hemorrhages, left ventricular enlargement (LVE), cardiomegaly, heart failure, myocardial infarction, renal damage, and stroke.

Public Health Service Hospitals Cooperative Study Group[4-6]

Selection: Ambulatory patients, 80% male, were randomized to placebo or active variable chemotherapy only if they were reliable and DBP was stable between 90-114 mm Hg by multiple measurements at different visits. Benefits from chemotherapy could not be demonstrated unless LVE or ECG abnormalities pre-existed. There was a rise in DBP above 114 mm Hg in 12% on placebo.

Hypertension Detection and Follow-up Program Cooperative Group[7-10]

Selection: BP was measured in the homes of targeted populations. A second measurement was taken in a testing area. If the average DBP was 90 mm Hg, the

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Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

patient was eligible for the clinical trial. Some already had cardiovascular-renal complications. This was *not* a placebo versus active drug design. Half of the patients were assigned to stepped care (SC), highly specialized treatment centers with the goal of DBP reduction. The others were referred to their usual source of treatment or no treatment (RC). The SC group received comprehensive, convenient, free medical care. In contrast, the RC group did not receive equal medical care, and at times, none. Most likely it was not comprehensive. This is a major flaw in the study design. It is difficult to ascribe differences in morbidity and mortality in the two groups solely to differences in BP control. The DBP in 5 years was significantly lower in the SC group. The overall mortality and number of strokes were significantly lower in the SC group. Mortality was lower in the SC as compared to RC group, when entry DBP was 90-104 mm Hg. However, there was no significant difference for those age 30-49 and for white women. Thus, the significant difference related to being over 50 years of age. The incidence of stroke was not significantly different between the two groups for DBP between 90-104 mm Hg. In the SC group, 13% achieved goal BP reduction without chemotherapy.

Hypertension-Stroke Cooperative Study Group[11]

Selection: Ambulatory patients with DBP between 90-115 mm Hg and stroke or transient ischemic attack within the previous year were randomized to placebo or chemotherapy. The active treatment did not significantly reduce the incidence of recurrent strokes. When the DBP was 100-115 mm Hg, more patients on placebo progressed to heart failure.

Oslo Study[12]

Selection: Males were invited and BP measured on two visits. If the DBP was 90-109 mm Hg, the patients were randomized to active chemotherapy or no drug. None had evidence of cardiovascular-renal complications. No significant benefit from treatment could be demonstrated. There was a significant rise in BP of 17% not receiving treatment. All were under 50 years of age.

Management Committee of the Australian Therapeutics Trial of Mild Hypertension[13-14]

Selection: Volunteers with DBP between 95-109 mm Hg on two separate visits were entered in a random placebo versus chemotherapy trial if they had no cardiovascular-renal complications. During placebo, the DBP fell below 100 mg Hg in 80%, 95 mm Hg in 48%, and 90 mm Hg in 25%. It exceeded 109 mm Hg in 12%. Thus, while on placebo, only 40% continued with a DBP between 95-109 mm Hg. Only those with DBP consistently above 100 mm Hg benefited from chemotherapy with less morbidity and mortality. There were more complications on active drug as compared to placebo when the DBP in both groups was below 100 mm Hg on follow up.

Conclusions

What conclusions can be reached from the above data? First, BP should be measured carefully during controlled casual conditions and on several visits. When DBP is in the range of 90-109 mm Hg, often, over several months, it will drop below 90-95 mm Hg. A smaller number will rise to levels consistently above 104 mm Hg. These will need chemotherapy. When the DBP is consistently greater than 90 mm Hg in the age range of 50-74, chemotherapy is probably indicated. (Hypertension in the elderly may be different.) When the patient between 30-49 years of age has a DBP of 90-100 or 90-104 mm Hg, chemotherapy is indicated only when cardiovascular-renal complications co-exist. DBP consistently above 104 mm Hg in those aged between 30-74 should be reduced with chemotherapy.

When chemotherapy is not indicated, the patient must be seen at intervals. Weight reduction[15] and modest sodium restriction[16] can result in significant BP reduction and should be recommended.

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The Continuing Saga of Georgia's Medical Malpractice Statute of Limitations

ROBERT N. BERG, *Atlanta**

FIRST, THERE WAS *Hamby:*[1] the Georgia Supreme Court, in a case of first impression, upheld the constitutionality of the Georgia medical malpractice statute of limitations.[2] Specifically, the Court sanctioned the special rule created by the Georgia legislature in terms of the time at which a cause of action for medical malpractice accrues. (While a cause of action in most personal injury cases accrues at the time the injured person becomes or should have become aware of the wrongful act, a cause of action for medical malpractice accrues at the time of the wrongful act, regardless of whether or not the injured person knew of that wrongful act.) Then, there was *Allrid I:*[3] the Georgia Supreme Court, reaffirming and relying upon *Hamby,* upheld the constitutionality of that portion of the Georgia medical malpractice statute of limitations distinguishing between medical malpractice actions generally and malpractice actions based upon "foreign objects" left in a patient's body. (While traditional malpractice cases must be brought within 2 years of the occurrence of the wrongful act, "foreign object" cases must be brought within 1 year of the date upon which the wrongful act was discovered.[4]) More recently, there was *Clark:*[5] the Georgia Supreme Court determined that wrongful death actions based upon malpractice were different from malpractice actions in which the patient did not die; as a result, the Court found unconstitutional the application of the Georgia medical malpractice statute of limitations to wrongful death (as opposed to personal injury) actions. (While the medical malpractice statute of limitations can be applied to bar a personal injury case not brought within the prescribed period, it cannot be applied to bar a wrongful death case not brought within the same period.)

Now there is *Allrid II,*[6] a decision recently handed down by the Georgia Court of Appeals which raises serious questions about the continuing viability of the application of the Georgia medical malpractice statute of limitations even in personal injury cases.[7]

Allrid I

For several years, Georgia's medical malpractice statute of limitations fared well in surviving constitutional challenges. For example, in *Allrid I,* a medical malpractice lawsuit was instituted by a patient and his wife against a hospital and certain others for injuries allegedly sustained as a result of a diagnostic procedure which took place in February, 1956, in which a radioactive substance known as Thorotrast was used. This substance was discovered still to be present in the patient in March, 1979, and was alleged by the patient to be the cause of his chronic sore throats, debilitated physical condition and, ultimately, his death.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

In 1981, the trial court granted the hospital's motion for summary judgment on the grounds that the medical malpractice statute of limitations barred the medical malpractice action, since the action was filed in 1979, more than 2 years after the time (1956) during which the alleged wrongful action (the use of Thorotrast) occurred. On appeal, the Georgia Supreme Court affirmed the trial court's decision, and, in doing so, upheld the constitutionality of the medical malpractice statute of limitations. In the Court's view, the imposition of a finite limitation on the period of time during which a medical malpractice claim may be instituted, so as to allow medical practitioners to be free, at some point in time, from the necessity of defending stale claims, was a legitimate legislative function:

> "While we are not unsympathetic with [the patient's] dilemma, this case exemplifies the necessity of establishing rules which will bar stale claims: the alleged event leading to [the patient's] injury occurred a quarter of a century ago; the physician who allegedly injected Thorotrast into [the patient] is deceased; and the record clearly shows that physicians on staff at Emory at the time the angiogram was performed have, understandably, vague recollections of the events surrounding [the patient's] case."[8]

Clark

Hamby and *Allrid I,* taken together, suggested that the Georgia medical malpractice statute of limitations could provide meaningful protection for physicians in defending against malpractice actions. However, in January, 1983, the Georgia Supreme Court decided *Clark*. In that case, the plaintiff instituted an action for the wrongful death of his wife *within 2 years of the date of her death,* but *more than 2 years from the date of the malpractice* which allegedly caused her death. The trial court, applying the Georgia medical malpractice statute of limitations, granted the defendants' motion for summary judgment, holding that the claim was barred by the statute of limitations.

On appeal, the Supreme Court reversed, finding that the application of the medical malpractice statute of limitations to wrongful death actions had no rational basis and, therefore, was unconstitutional. In the Court's view, the purpose of a statute of limitations was to:

> ". . . promote justice by preventing surprises through the revival of claims that have been allowed to slumber until evidence has been lost, memories have faded, and witnesses have disappeared. The theory is that even if one has a just claim it is unjust not to put the adversary on notice to defend within the period of limitation and that the right to be free of stale claims in time comes to prevail over the right to prosecute."[9]

However, the court could not bring itself to apply the medical malpractice statute of limitations to the wrongful death action in this case, reasoning that since a wrongful death action does not accrue until a death has occurred, it would be improper to bar a claim for wrongful death prior to the date of the death.

Allrid II

Meanwhile, *Allrid* was back in the trial court, where the plaintiff, relying upon *Clark,* claimed that she had a viable wrongful death claim which was not barred by the statute of limitations. Fortunately (for the plaintiff), a five-judge majority of the nine-member Court of Appeals agreed, holding that the allegations in the Complaint, taken as a whole, set forth a cause of action for wrongful death, which cause of action, as a result of the Supreme Court's decision in *Clark,* was not barred by the medical malpractice statute of limitations. Thus, the Court remanded the case to the trial court for a decision on the wrongful death issue.[10]

Unfortunately, the Court of Appeals did not stop there. Rather, the Court went further and offered what is termed "*obiter dicta*" — statements in an opinion in which the Court indulges in generalities that have no actual bearing on issues

involved in the case before it. Specifically, the Court of Appeals suggested that the Supreme Court's decisions in *Allrid I* and *Clark* were totally inconsistent; to the Court of Appeals, it appeared "illogical to hold that the statute of limitations for medical malpractice claims is constitutional when applied to a personal injury claim and yet unconstitutional when applied to a wrongful death claim based upon the same set of facts."[11]

The Court then went on to explain the reasoning for its conclusion:

> "The result of the decision in *Allrid [I]* and *Clark* is to bar suit for medical malpractice after a 2-year period during which the injury may not even have been discoverable by the patient, yet allow suit based on the same tortious act after the patient has died. . . .
>
> . . . If [the medical malpractice statute of limitations] is unconstitutional because it might cut off a wrongful death action before it accrues, then surely it is also unconstitutional because it might cut off a personal injury claim before it accrues the same as any other such claim. A citizen's right to litigate with another citizen should not be decided on technicalities."[12]

As a result, the Court of Appeals urged that the Supreme Court reconsider and overrule its decision in *Allrid I*.

Conclusion

Technically, the law in Georgia as to the constitutionality of the medical malpractice statute of limitations has not been changed by the Court of Appeals' decision in *Allrid II:* the application of that statute to medical malpractice actions alleging personal injuries remains constitutional, while the application to wrongful death medical malpractice actions remains unconstitutional. Nonetheless, in light of the fact that all nine judges on the Court of Appeals appear to agree that the medical malpractice statute of limitations should not be constitutional as applied to personal injury medical malpractice cases, it can be expected that the issue should soon be squarely before the Supreme Court.[13] Until that time, it is at least questionable whether a trial court will grant a motion for summary judgment on behalf of a defendant physician or hospital on the grounds that the 2-year period within which to bring a personal injury medical malpractice action has run and therefore bars the claim.

[Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power either to affirm or to reverse the decision of the Georgia Court of Appeals, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article, although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. In the event that the case discussed in this article is appealed and subsequently reversed by the Georgia Supreme Court, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.]

Notes

1. *Hamby v. Neurological Associates, P.C.*, 243 Ga. 698 (1979).
2. O.C.G.A. §9-3-70 *et seq.*
3. *Allrid v. Emory University*, 249 Ga. 35 (1982).
4. O.C.G.A. §9-3-72.
5. *Clark v. Singer*, ___ Ga. ___ (January 4, 1983).
6. *Allrid v. Emory University*, ___ Ga. App. ___ (March 17, 1983).
7. For a more detailed look at these cases, see: Goodman M *Allrid v. Emory University*, Applying Georgia's medical malpractice statute of limitations in a difficult case, JMAG (August, 1982); Berg RN. Applying Georgia's medical malpractice statute of limitations in "foreign object" cases, JMAG (February, 1983); Berg RN. Georgia's medical malpractice statute of limitations declared unconstitutional as applied to wrongful death actions, JMAG (March, 1983).
8. *Allrid v. Emory University, supra*, 249 Ga. at 39.
9. *Clark v. Singer, supra*, ___ Ga. at ___, quoting *Order of Railroad Telegraphers v. Railway Exp. Agency*, 321 U.S. 342, 348-9 (1943).
10. Four judges dissented from the majority's decision, believing that the plaintiff's wrongful death claim, even if raised, had been disposed of by the trial court's grant of summary judgment to the defendant. However, all nine judges appeared to agree that the Supreme Court's decision in *Allrid I* and *Clark* were not reconcilable.
11. *Allrid v. Emory University, supra*, ___ Ga. App. at ___.
12. *Id.*
13. In fact, the defendant hospital in *Allrid II* has filed a motion requesting that the Court of Appeals reconsider its opinion. Should that motion be denied, the hospital might choose to file an appeal with the Georgia Supreme Court.

cancer page
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cancer page

The Cell and the Celestial: Spiritual Needs of Cancer Patients

JIM EPPERLY, *LaGrange**

DESPITE the vogueish concept of "wholistic" care, the reality remains that the medical community has yet to feel a sense of urgency about meeting the spiritual and emotional needs of cancer patients. Much of this lack of urgency rises from a questionable assumption of our time, that the body *is* the person. A more helpful approach to persons who have cancer is to view the body as a *part* of the person, which includes a person's social, mental, emotional, and spiritual dimensions.

This concern for the non-body needs of patients is as old as medicine itself. In ancient Greece, while Hippocrates prefaced his medical oath with a pledge to the gods, Plato is recorded as saying that "it is a mistake to treat the body without treating the mind; the mind and body are one and cannot be treated separately." At the same time, in the Middle East, Israel's sages were teaching that tending to the affairs of the spirit promoted physical health and longevity. Another relevant historical fact speaking to the interdependence of spiritual and physical health is the fact that the words, "whole," "holy," and "health" all derive from the same Old English word "halus." When dealing with the needs of cancer patients, then, we need to consider not only the cell but also the celestial — not only the needs of the body but also of the spirit as well.

Thomas Carlyle, the 19th century British philospher, observed that "there is an infinite in man that, despite all of his cunning, he cannot bury under the finite." Likewise, our system of health care, with its emphasis on the finite, must continue to expand its vision if it is to care for the infinite needs of cancer patients. This vision of the whole person in medical care is firmly supported in the Christian tradition.

Jesus of Nazareth, when describing the qualities of a faithful disciple says, "When I was sick you visited me." The Greek word for visit here is *episkōpe,* which is translated "to inspect; to look over diligently; to oversee." The gist of the word implies a vision of the person which involves an overarching panorama of the needs of the whole person. This concept is the forerunner of the current wholistic care movement.

A careful reading of the healing accounts of Jesus indicate that the majority, particularly in the Gospel of Mark, are followed by a peculiar warning to the disciples and/or person healed; "Go and tell no one about what has been done." Why this request? A consensus among biblical scholars is that Jesus did not want

* Mr. Epperly is Chaplain at the West Georgia Medical Center. Send reprint requests to him at the Center at 1514 Vernon Rd., LaGrange, GA 30240.

Prepared at the request of the Georgia Division, American Cancer Society.

the broadcast of these healings to give a distorted message that the needs of the body might be seen as transcending the need of the mind, emotions, and spirit. Rather than have this vision of man projected, he requested, to no avail, that these healings not be mentioned at all. Jesus' concern, however, has largely come true in our time as we urgently wage war against death and disease and yet casually seek to meet the needs of the spirit.

Luke, despite his status as the only physician mentioned in the biblical literature, includes fewer references to physical healing than any of the synoptic gospels. This would imply that a traditional prototype for medical care, a Christian physician, was concerned that the needs of the physical body not be seen to supercede the needs of the whole person.

What are some infinite, spiritual needs that are especially relevant to cancer patients?

The Need for Meaning

Vicktor Frankl, a renowned psychiatrist and a veteran of Auschwitz, suggests in his writings that man can endure any suffering, however intense, if he has a purpose and meaning to his life. In order to effectively cope with the physical suffering of cancer, it is imperative that patients be able to claim a definitive purpose for their lives — that they be able to answer the question: "Why am I here?"

One of the things I observe often in cancer patients is a passive attitude toward their disease. Cancer is often seen as an attacker from outside of themselves which is often met with little determined conscious resistance. I feel that a passive attitude is related to a lack of meaning in life. When there is no motivating purpose for living, then the cancer patient will be limited in his/her will to live. The stronger the will to live, the better the chance for a positive response to treatment. In order for us to mobilize a patient's will to live, we must, naturally, have first identified the meaning life holds for us. If we can help mobilize our patients to discover the "Why" for their lives, I am convinced that this will make a difference, if not in the medical management of cancer, at least in the ability of our cancer patients to cope with their suffering.

The Need for Relatedness

Cancer patients have a deep need to feel they have a significant worth to those around them. In many ways, their sense of relatedness with others is collapsing. In many cases, a patient's role as a worker, spouse, lover, parent, citizen, and friend is undergoing radical change. Our cancer patients need to know that despite the changes occurring in the way he/she relates to the significant others around him/her, that he/she is still of worth as a person. Self esteem in cancer patients is consistently low because of the many losses in the area of relatedness to others, particularly as they are thrust into the patient role as a dependent receiver of care. We can help by honestly and sincerely communicating, whether directly or indirectly, our respect for that person's value as a person. We can relate to them not as cancer patients but as a person who happens to have cancer. We can help teach the person with cancer that his/her relatedness to the world is not ending, just changing; that their roles as spouse, lover, parent, worker, etc. are not ending but undergoing adjustment.

The Need for Hope

Proverbs observes that "without hope the bones rot." A sense of hope helps maintain the body's recuperative capabilities. Persons with cancer maintain their need for hope throughout the course of their illness. When diagnosed, the hope is that there is some mistake in the tests. When the tests are confirmed, the hope is that it is not serious. When it is serious, there is hope for a cure. When there is no cure, there is hope that they can live a long time with their cancer. When there is little time, there is hope that they can make it till Christmas or some other occasion such as a wedding or birth of a grandchild. When they will not make it till the birth of the

grandchild, the hope is to make it through the week. When they realize they cannot make it till tomorrow, the hope is to make it a few more hours.

While reinforcement of false hope, which may be a form of denial, probably is not helpful, nevertheless, the maintainance of hope at whatever stage is a spiritual need of the persons we care for who have cancer.

The Need for Love

Persons with cancer can tolerate anything if they feel they are loved and if they are allowed to give love. They may not be able to work like they once could, or walk, play, or go to the bathroom like they once could, but they can still feel and experience love like they used to — perhaps even more so. When a patient considers his/her mortality and looks out into the darkness of death, priorities often change. Many cancer patients discover that their ultimate need is to love and be loved. Unfortunately, a person with cancer often questions whether he/she is still lovable with a deteriorated physical body and a collapsing social world. We need to take every opportunity we can to reinforce the love we see expressed by spouses, children, and friends, as well as to express our own feelings of regard to our patients.

Studies of bachelors reveal that on the average their lives are shorter and less healthy than those of married men. One implication is that the experience of loving and being loved has a measurable effect on the immunologic system. It is important, then, to facilitate the expression of affection from family as well as staff. If the spiritual love need is met, patients will be likely to cope better and be more likely to be in an optimum state of responsiveness to medical treatment.

The above are some of the spiritual needs that we will find in persons with cancer as we "diligently inspect" and "oversee" the whole picture of their disease. Our work can have increased meaning and relevance as we seek to be faithful to our Christian tradition of viewing persons with disease as having multi-dimensional needs. In addition to treating a body, and in addition to seeking to meet infinite needs of persons with cancer, our work can be vitalized by our awareness that "in so much as you have done it unto one of the least of these my brethren, you have done it unto me." As we care for persons with cancer, may the cell and the celestial be part of our vision.

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J-9043-4 July 1981



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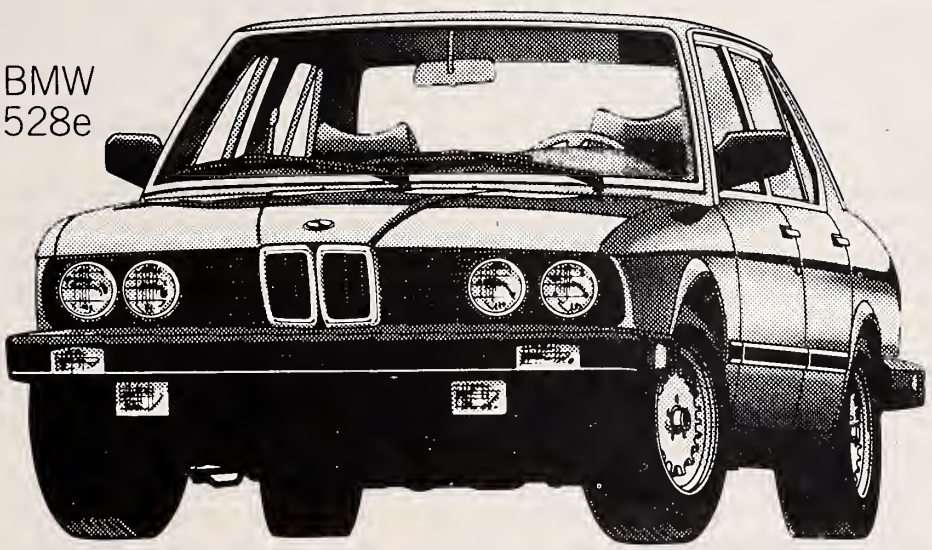
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president's letter



Buzz Words

THIS IS THE FIRST of twelve "Letters" that I will be writing for the *Journal* during my tenure as President of the MAG. This is certainly one of the great opportunities and awesome responsibilities of the job: communicating to the membership a description of problems facing us in medicine, an evaluation of possible solutions, and recommendations for action.

The list of problems facing us is indeed awesome. A newly practicing physician who heard me speak at a hospital staff meeting regarding the Joint Commission on Accreditation of Hospitals' changes in the Manual told me afterwards that he wasn't at all sure he really wanted to continue practicing medicine but perhaps start over in some new field. I had no idea I sounded that pessimistic but it acutely sensitized me to the need to speak carefully less I misrepresent the situation. I intend in the next 12 months to bring you my opinions on a variety of subjects, almost all of which may be subject to differing interpretations. I think it is most important to recognize the fact that there *are* differing interpretations about the problems that face us, and there is a necessity for us to hammer out an acceptable path of action and to avoid the kind of divisiveness that thwarts our efforts.

It is difficult for me to pick a "most important" issue. However, for better or worse, I will choose "competition in medicine." This is a new buzz phrase that is widely spouted and rarely defined. It is my considered opinion that there is less understanding about the various aspects of competition in medicine than perhaps any other issue that faces us. One goal I would like our organization to make is to define the various aspects of competition, evaluate their potential and real effects upon us, and propose useful recommendations for their solution.

There may be many definitions of the problem. My own tends to begin with a gut feeling that our greatest competition is from the entire spectrum of third party payers which include the individually responsible patient, the private health insurers, the "government" including Medicare, Medicaid, Champus, and a variety of federal, state, and more rarely, local programs. In addition, there is even serious competition within our own ranks. For example, there is the search for "turf" — a four letter word that frequently arouses more emotional than intellectual concern. There are divisions among us that cause us to compete for practice in various areas and to cut the throats, so to speak, of another group of physicians within the community or specialty just to stay ahead.

There is competition among the groups involved in what is loosely termed "health care." These include a wide variety of limited practitioners within and without the medical and nursing areas, paraprofessional groups, and others who are not so interested in assuming our practices as they are in managing our practices.

It seems to me that a scientific evaluation of these forces, their potentials, and solutions to the problems they present is sadly lacking. I hope that during the coming year we can address these problems fairly and intelligently to enable us to better understand and deal with the realities of these new situations.

William W. Moore, Jr., M.D.

NEW MEMBERS

Adamson, James, Muscogee—Service—IM
Dept. of Medicine, Martin Army Hospital, Ft. Benning 31905

Behrmann, Paul J., Lumpkin—ACT—FP
Highway 53 West, Dawsonville 30534

Brown, William M., Cobb—ACT (N-2)—IM/CD
833 Campbell Hill St., Marietta 30060

Bullock, Huey G., Richmond—ACT—DR
820 St. Sebastian Way, Ste. 1-A, Augusta 30901

Causey, David A., Lumpkin—ACT—R
Lumpkin County Hospital, Dahlonega 30533

Coalson, Barry E., Richmond—Student
1300 Warren Hites Dr., Apr. C-105, Augusta 30901

Cochran, J. Sydney, Decatur-Seminole—ACT—IM/PD
1504 E. Evans St., P.O. Box 385, Bainbridge 31717

Cohen, Louis V., Bibb—ACT (N-2)—FP
3225 Pio Nono Ave., Macon 31206

Dunkelberger, John A., Glynn—Retired—OTO
139 Belle Point Parkway, Brunswick 31520

Farkas, Stephen J., Hall—ACT (N-2)—OPH
664 Lanier Park Dr., NE, Gainesville 30501

Friedler, Edward M., Muscogee—Service—FP
Martin Army Hospital, Ft. Benning 31905

Garner, Steven R., Bibb—I & R—FP
Medical Center of Central Georgia, Macon 31208

Griffiths, Glenn C., Muscogee—Service—FP
Family Practice Clinic, Martin Army Hospital, Ft. Benning 31905

Hostetler, Russell M., Bibb—I & R—FP
784 Spring St., Macon 31201

Hwang, Steve K., Clayton-Fayette—ACT (N-1)—GS
7429 Hwy. 85, P.O. Box 590, Riverdale 30274

Jewson, Douglas V., Ogeechee River—ACT—IM
Willingway Hospital, P.O. Box 508, Statesboro 30458

Jones, Arthur D., Jr., Glynn—ACT—PTH
Glynn-Brunswick Hospital, 3100 Kemble Ave., Brunswick 31520

Jones, Jonsey J., DeKalb—I & R—AN
4005 Grantland Dr., Tucker 30084

Junco, Aida G., Bibb—I & R—FP
Medical Center of Central Georgia, Macon 31208

Junco, Hector A., Bibb—I & R—FP
Medical Center of Central Georgia, Macon 31208

Lennox, Kenneth W., Richmond—ACT—U
VA Medical Center, Augusta 30910

Lin, Gerald H., Troup—ACT (N-2)—U
303 Smith St., LaGrange 30240

Mandal, Anil K., Richmond—ACT—IM/NEP
VA Medical Center (111F), Downtown Division, Augusta 30910

McNair, George R., Thomas Area—ACT (N-2)—AN
c/o John D. Archbold Memorial Hospital, Thomasville 31792

Mundy, H. Brent, Carroll-Haralson—ACT—U
Groover Medical Building, Carrollton 30117

Phurrough, Steve E., Muscogee—Service—FP
Martin Army Hospital, Ft. Benning 31905

Pradhan, Medha A., Laurens—ACT (N-2)—AN
Dublin VA Medical Center, Dublin 31021

Reagan, Ronald C., DeKalb—I & R
300 Boulevard, NE, Atlanta 30312

Retterbush, David W., South Georgia—ACT (N-2)—GS
403 Cowart Ave., P.O. Box 2313, Valdosta 31601

Roberts, Terrell S., Bibb—I & R—FP
784 Spring St., Macon 31201

Sklar, Allan H., Richmond—ACT (N-2)—IM/NEP
BA—N646, Medical College of Georgia, Augusta 30912

Slaughter, William G., Thomas Area—ACT—P
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Spain, Stephen D., Bibb—I & R—GS
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Takagi, Luis R., Clayton-Fayette—ACT—OBG
189 Medical Way, Ste. B., Riverdale 30274

Wellborn, Roger G., Bibb—I & R—FP
784 Spring St., Macon 31201

Whitlock, Richard R., Richmond—ACT—IM
Section of Cardiology, Medical College of Georgia, Augusta 30904

PERSONALS

First District

Charles E. Drake, M.D., Savannah cardiologist, presented an abstract in March at the 32nd Annual Scientific Session of the American College of Cardiology in New Orleans. The paper is entitled "The Effect of Bundle Branch Block on the Diagnostic Accuracy of Exercise Radionuclide Angiograms."

Second District

Moultrie physician, **Dale L. Kile, Jr., M.D.,** was recently elected to fellowship in the American Academy of Pediatrics.

Fifth District

R. Bruce Logue, M.D., of Atlanta, was honored at the second annual Atlanta Heart Ball in March. Dr. Logue was the founding president of the Georgia Heart Association.

James F. Glenn, M.D., who recently announced his resignation as dean of the Emory University School of Medicine, has been named president and chief executive officer of the Mount Sinai Medical Center in New York effective June 1. Dr. Glenn will also assume temporary responsibility as acting dean of the Mount Sinai School of Medicine, beginning in July with the retirement of the current dean, until a permanent one can be found. Dr. Glenn had become dean of the Emory School of Medicine in August, 1980, after serving as chief of the division of urologic surgery at the Duke University Medical Center in Durham, NC.

Seventh District

Brent H. Mundy, M.D., a specialist in urology, recently opened a new practice in Carrollton.

Eighth District

Robert Pumpelly, IV, M.D., has opened a practice of internal medicine in Jesup.

Tenth District

J. Dewey Gray, M.D., Augusta physician, was honored recently for 61 years of service in the medical profession. Dr. Gray still sees patients and makes house calls to patients who can no longer get to him.

John C. H. Steele, Jr., M.D., Assistant Professor in the Department of Pathology and Medical Director of the clinical microbiology laboratory at the Medical College of Georgia, has been elected a Fellow of the College of American Pathologists.

DEATHS

Oscar H. Lott

Oscar H. Lott, M.D., of Savannah, died February 17, at the age of 72. Dr. Lott graduated from the Medical College of Georgia in 1935. He practiced medicine in Savannah from 1938 until his retirement in 1964. He was past president of the medical staff of the Telfair Hospital and Candler Hospital and was a member of the surgical staff of Candler General and St. Joseph's and Memorial hospitals.

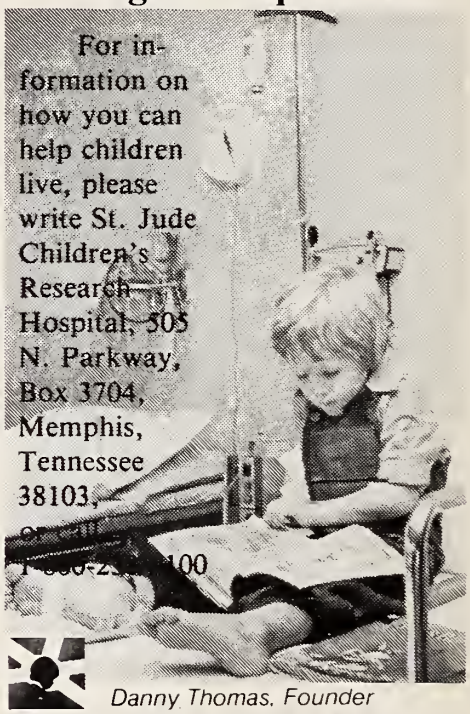
Dr. Lott is survived by his wife, one daughter, two sons, two brothers, one stepsister, and two grandchildren.

Charles E. McArthur

Charles E. McArthur, M.D., 80, died March 14. Dr. McArthur had practiced medicine in Cordele for the past 52 years. He was a graduate of the University of Arkansas School of Medicine. He was past president of the Georgia Academy of General Practitioners. He also served as chairman of the Georgia Lung Association.

Survivors include several nieces and nephews.

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WE'RE FIGHTING FOR YOUR LIFE

Highlights — MAG Executive Committee Meeting — March 13, 1983

Operation Care, Inc. — Medical Care for the Temporarily Unemployed

The Executive Committee enthusiastically endorsed and supports a program to provide free medical care to those who are temporarily unemployed or otherwise not being provided medical care. This project will begin in a 12-county metropolitan Atlanta area. Physicians are being asked to volunteer their services to treat such patients referred to them by a program called Operation Care, Inc. A number of groups such as those representing nurses, pharmacists, hospitals, the Auxiliaries, and others are being asked to participate. The plans are that the project will eventually become statewide in scope.

Physician Recruitment

The Access to Health Care Committee's plan to recruit physicians for those counties in Georgia designated health manpower shortage areas was approved. The Appalachian Regional Commission will provide part of the funds, and the committee will seek a grant from private foundations to supplement the federal grant.

Flex I, Flex II

The Executive Committee voted to support the Accreditation Council for Graduate Medical Education (ACGME) and the recommendations of the deans of the state's four medical schools to oppose the Federation of State Medical Education Board's plan for a "Flex I-Flex II" pathway to medical licensure.

Membership Benefits

The following items were approved to be included in a membership benefits package to offer such services to the MAG membership: (1) a magazine subscription service, (2) an office supplies discount buying plan, (3) and a professional filing system discount buying plan.

Meeting With DMA Representatives

The Executive Committee met with several representatives of the Department of Medical Assistance (DMA) in an effort to resolve problems of reimbursement with "mandatory outpatient services." Representatives of the DMA agreed with the Executive Committee that a cooperative atmosphere must be maintained between MAG and DMA in order to modify some of the problems connected with the surgical procedure list and other medical problems. The Executive Committee requested the Third Party Relations Committee to address the problems and report to the House of Delegates in April.

Committee Reorganization

In an effort to streamline and reorganize its committee structure, the Executive Committee discharged 13 MAG committees: Cost Awareness, Countersuit Review, Crawford W. Long Memorial Committee, Drug Committee, Health Planning, Mental Health, Screening Committee for Extra Mural Appointments, Transfusions and Transplantations, Truthful Advertising, Women in Organized Medicine, Ad Hoc Committee on Podiatric Education, Foreign Medical Graduates, and Ad Hoc Committee on Specialty Society Representation.

Certificates of Appreciation

The Executive Committee approved giving Certificates of Appreciation to 26 physicians and others of special service to the Association at the April House of Delegates meeting in Columbus: Charles D. Hollis, Jr., M.D., Mrs. David C. (Barbara) Thibodeaux, C. Rex Teeslink, M.D., W. Perrin Nicolson, III, M.D., Jack A. Raines, M.D., Henry S. Jennings, Jr., M.D., William W. Moore, Jr., M.D., Virgle W. McEver, Jr., M.D., Richard Griffin, III, M.D., James S. Mashburn, M.D., J. Dan Bateman, M.D., F. William Dowda, M.D., Senator Richard L. Greene, Representative Bobby Phillips, Representative Calvin Smyre, H. Duane Blair, M.D., Henry M. Finch, M.D., Evan L. Frederickson, M.D., Stanley Aldridge, M.D., Thomas J. Anderson, III, M.D., William C. Waters, III, M.D., Paul F. Jurgenson, M.D., Kenneth D. Jones, M.D., Lillas L. James, M.D., Charles Allard, M.D., W. Frank Matthews, M.D., Edward C. Loughlin, M.D., Jeffrey T. Nugent, M.D., Joe C. Stubbs, M.D., and Lois T. Ellison, M.D.

MAG/GHA Joint Advertising Campaign

The Executive Committee agreed to participate in a joint MAG/Georgia Hospital Association (GHA) radio advertising campaign. The GHA has had an on-going advertising program on most Georgia radio stations for over a year. MAG will script two commercials designed to show the positive results of physicians and the hospitals working together in the public interest. These "spots" will air across the state in April.

Classifieds . . .

PHYSICIAN WANTED

Internist and Family Practitioner — Five Physician Multi-specialty Group in East Central Georgia seeks two additional Board certified/eligible physicians with specialties in internal medicine and family practice. Liberal first year salary/guarantee, paid malpractice, vacation, and educational leave. For additional information contact Dr. W. Rawlings, Jr., 522 Washington Ave., Sandersville, GA 31082 or call (912) 552-6051 days; (912) 552-6353 evenings after 9:00 p.m.

Industrial clinic needs physician for large facility located in Atlanta, Georgia area. Prefer Board certified in occupational medicine, family practice or emergency medicine. Competitive salary with good fringe benefits, etc. Please reply, giving complete resume and recent photograph to Box 5-A, c/o Journal.

Associate Medical Director — Atlanta, Georgia. Board certified (or eligible) Internist or Cardiologist for home office of rapidly growing life reinsurer. Prior life insurance experience desirable but not pre-requisite. Suburban location. Excellent working conditions and employee benefits program. Munich American Reassurance Company, P.O. Box 3210, Atlanta, GA 30302.

Busy North Atlanta two-man Family Practice group looking for third doctor. Contact (404) 256-1903 for more information.

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Family practice opportunity — Established 2 years, Stockbridge, GA, 18 miles from Atlanta, 1250 sq. ft. office: 104-bed hospital, 5 miles from office. 322-bed hospital 10 miles from office. Reason for leaving, personal. For information call (404) 474-1461 or (404) 474-1324.

2,600 Square Feet Prime Medical Office Space for lease, 5669 Peachtree Dunwoody Rd., NE, St. Joseph's Doctors Building I. Located across from Northside Hospital, Scottish Rite Hospital and St. Joseph's Hospital. X-ray and lab. facilities, carpet, cabinetry, decorator wall coverings. Available immediately. Contact (404) 256-1903 for more information.

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Board eligible 35M anesthesiologist, trained in all fields including open heart and epidural anesthesia. Available July, 1983. Call (215) 329-8958 or write Vithal Kardani, 408 Elkin Residence, 5501 N. 11th St., Philadelphia, PA 19141.

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Position Desired: (metro Atlanta) administrative assistant/editorial assistant in medical or health-related environment. Seven year's experience typing, editing, proofreading complex laboratory procedures, seminar/conference material and correspondence in health-related/laboratory environments. Degreed, mature, intelligent, conscientious female displays professional demeanor and animated personality. Works well at all levels of management and staff. Reply to Box 5-B c/o Journal.

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	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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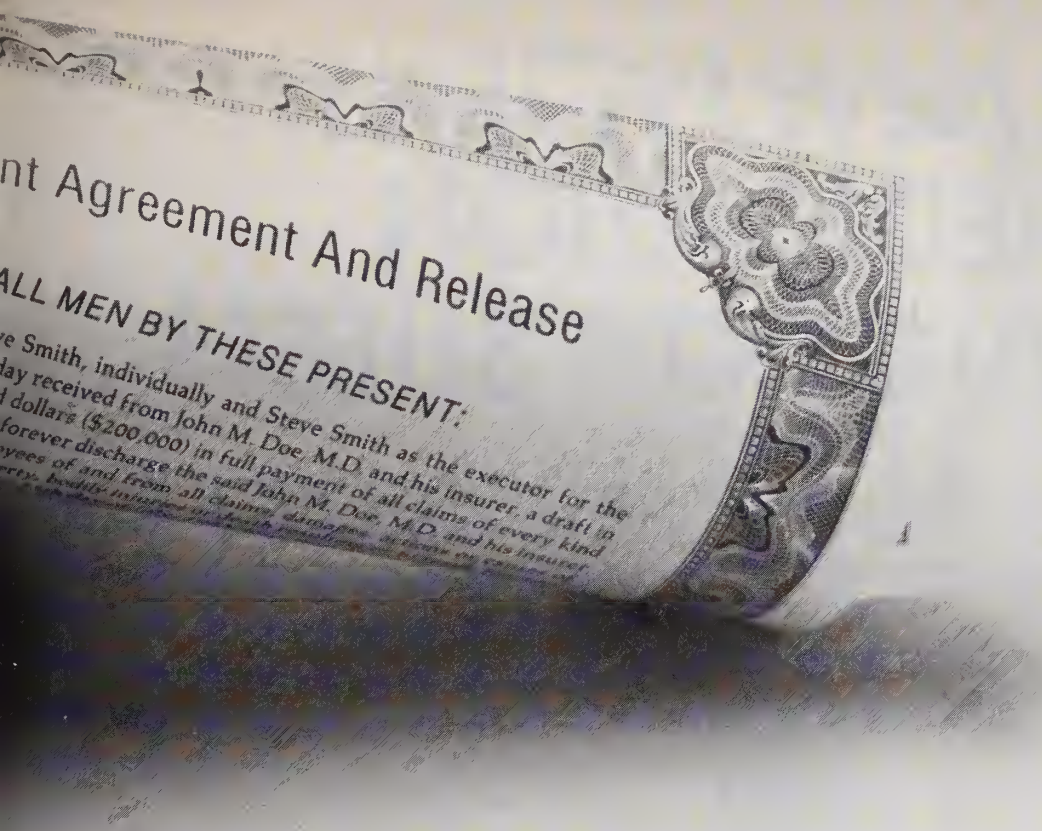
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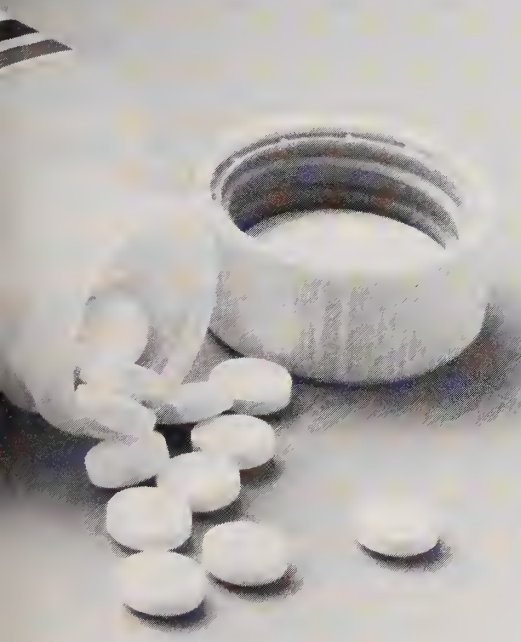
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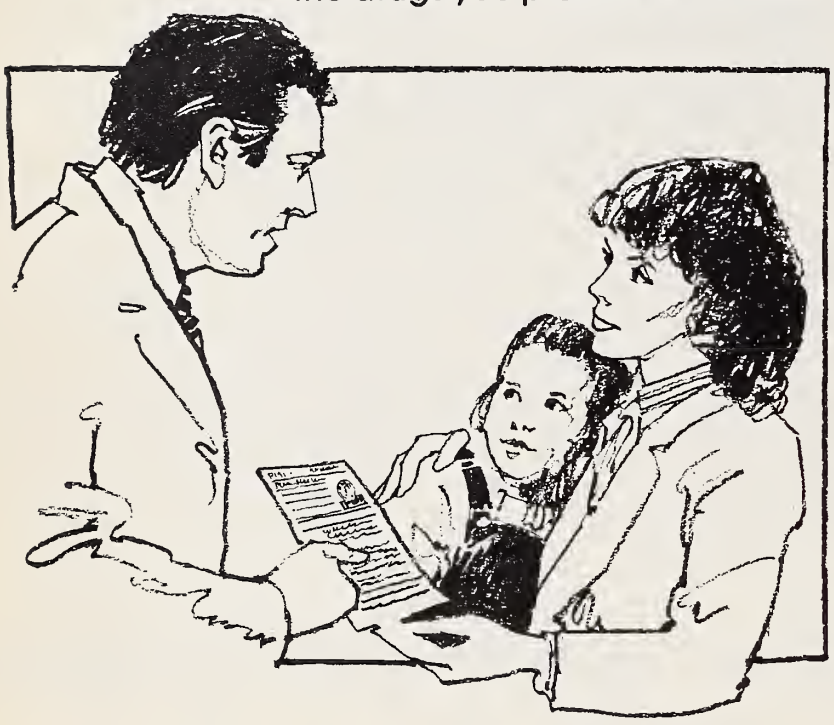
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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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COVER

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president's letter



A Half Step Forward

At our recent Annual Session, the House of Delegates gave approval by a narrow margin to a proposal for direct Specialty Society representation in the House. Since this requires a change in the Constitution, this item will lie on the table until the next Annual Session when it will be voted upon.

The internal discussion at both the Reference Committee and on the floor of the House clearly demonstrated a diversity of both understanding and opinion. I sincerely hope that during the year we can come closer to unanimity.

Opposition substantially centered on concerns about:

(1) dilution of representation of local Society delegates;

(2) proliferation of representation by multiple small groups of subspecialties; and

(3) the possibility that such representation by specialty societies would be primarily urban or opposed to non-urban.

Proponents, of whom I am one, feel that

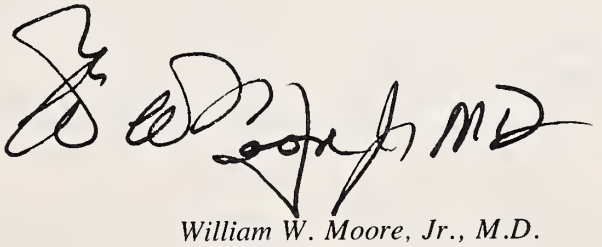
(1) better communication and participation with the Specialty Societies is a present and increasing need of both MAG and the Specialty Societies;

(2) that the parameters of eligibility are such that representation can be kept reasonable;

(3) that the AMA experience has been fruitful; and

(4) that the trend toward separation and isolation of the two groups can be at least slowed and hopefully reversed.

We have made great strides in the past few years in establishing good communication with many from whom we have been separated. I strongly urge your thoughtful consideration and support for this additional step in that direction.



William W. Moore, Jr., M.D.

MEDICAL MEETING CALENDAR

JUNE

13-17 — *Lake Arrowhead:* **Orthopaedics.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

19-23 — *Atlanta:* **2nd International Symposium on Legionella.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

23-26 — *Orlando, FL:* **Arthroscopy Need Not Be Frustrating (Operative Arthroscopy).** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5696.

23-26 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-2967.

JULY

11-12 — *Atlanta:* **MKSAP VI — Part III — ACP.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Kiawah Island, SC:* **Clinical Obstetrics.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

18-21 — *Hilton Head, SC:* **Clinical Cardiology.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

19-23 — *Hilton Head, SC:* **Sixth Annual Symposium on Contemporary Clinical Neurology.** Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

22-23 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

25-27 — *Kiawah Island, SC:* **Pediatric Update 1983.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

28-31 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

1-5 — *Hilton Head, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

8-12 — *Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24-28 — *Hilton Head, SC:* **Summer Imaging.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

27-28 — *Callaway Gardens:* **Medical Malpractice and the Anesthesiologist.** Category 1 credit. Contact William Hammonds, M.D., Secy.-Treas., Ga. Socy. of Anesthesiologists, Emory Univ. Hosp., Dept. of Anesth., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

SEPTEMBER

11-14 — *Sea Island:* **Annual Meeting — Georgia Urological Association.** Contact Richard C. Estes, MD, Secy-Treas., 35 Collier Rd., NW, Atlanta 30309. PH:404/355-0813.

12-14 — *Atlanta:* **Echocardiography.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Savannah:* **Neonatology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-17 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Secy-Treas., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

26-29 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

6-8 — *Hilton Head, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, August 30912. PH:404/828-3967.

8-12 — *Atlanta:* **American Society of Anesthesiologists.** Contact ASA, 515 Busse Hwy., Park Ridge, IL 60068. PH:312/825-5586.

10-13 — *Atlanta:* **ACC Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-21 — *Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

19-22 — *Hilton Head, SC:* **Fifth Annual Hilton Head Symposium on the Clinical Management of Diabetes and Endocrine Disorders.** Category 1 and AAFM prescribed credits. Contact Edwin Bransome, Jr., MD, Dept. of Med., MCG, Augusta 30912. PH:404/828-3445.

22-27 — *Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P.O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

NOVEMBER

9-13 — *Atlanta:* **Georgia Academy of Family Physicians Annual Scientific Assembly.** Category 1 and AAFP prescribed credit. Contact GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

11-12 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

17-20 — *Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester Lane, Exec. Secy, 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

18-20 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree Street, NE. Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga).

editorial
editorial
editorial

Through the Looking Glass — 1983 Medicine

Let me commend to you a brief editorial in the March, 1983, issue of *Neurosurgery* written by a friend of mine, William H. Mosberg, Jr., M.D., of Baltimore, Maryland. In this intriguing treatise, Bill Mosberg deals with a problem that emanated from Georgia where a 29-year-old Savannah resident named Lacey sustained burns over 95% of his body. He was appropriately and effectively treated at the Memorial Medical Center and subsequently transferred to the Baltimore Regional Burn Center where he died 3 days later despite heroic care. There was extensive press coverage of this event in our own state and throughout the nation. Dr. Mosberg dealt with the outpouring of comments from the public and media editorialists that followed in the wake of this incident, particularly relating to the difficulties in finding a place of definitive treatment for this unfortunate victim.

Most of us here in Georgia will recall the more immediate instance of two burn victims who had a very transient delay in admission to the Burn Unit at Grady Memorial Hospital in Atlanta. The circumstances and underlying problems are virtually identical, and I believe they demand our attention and consideration.

In the case of Mr. Lacey, arrangements for transfer to a Burn Unit were effected only after some 20 hours and 43 separate telephone calls by the chief medical resident of the hospital in Savannah plus a personal guarantee by the then Governor of Georgia, George Busbee, that the state would be responsible for $50,000 of expenses. The Governor also said that if the state failed to meet its responsibilities, he would personally guarantee the costs. No financial flap of this magnitude was associated with the more recent Grady incident; however, the question of admission to the hospital revolved around the problem of staffing of the Burn Unit. The basic problem was similar to the one in Baltimore, that is, the financing of the public hospital by the government, which means by the public.

The costs of health care in our country are indeed staggering. A total of $287,000,000,000 was spent in 1981 for medical and hospital care and related services.[1] On one side of the looking glass, we have Senator Robert Dole (R-Kansas) proclaiming that, "Congress and the administration won't stand by this year while health costs increase at nearly double the rate of inflation."[2] On the other side, Harry Schwartz points out that, "We have adopted an ethic which declares in effect that everything medically possible must be done for every human being who has been born in this country."[3] Like the multiple mirrors in a barber shop, another two-sided image is presented by the perception of the public of regionalized medical care as representing a level of quality far superior to that that is available in any other setting. The insatiable cost demands associated with government funded health care due to inflation, high cost technology, and an aging population with concomitant need for increased medical care is generally ignored and apparently a part of the "Alice-In-Wonderland Syndrome."

From the standpoint of our MAG membership, it is in fact somewhat chilling and disappointing to note that we tend not to react to the outpouring of criticism that attends such an event as those noted above. Presumably, we have a great fear of getting into certain types of contests with skunks and, in Bill Mosberg's words,

"perpetuating adverse criticism." It is ironic that the most appropriate and vivid response to the public criticism that was directed at the medical profession, not at the government that created the financial circumstances of the involved hospitals, was made by a mild mannered individual not known for public statements who responded as follows:

> The failure of the involved hospitals to render care to Mr. Lacey is not a failure of the capitalist system. When hospitals were under the capitalist system (they are no longer), this man would have been taken care of immediately in any hospital equipped to handle his problem. The failure is in the present socialist system under which modern medicine is forced to operate. Under this system there is no provision for people who are not in some way covered by the government, by private insurance, or by welfare. The hospitals have expenses (salaries, utilities, supplies), but they cannot recover these expenses from patients of this type who cannot pay, or from the state, which will not pay unless all of the picayune state regulations are fulfilled. The complaint should be directed to the state politicians.[4]

No physician would or did fail to give high grade care to this patient. The failure rests entirely with the government for which all citizens are responsible. It is sad to note that there were 42 hospitals unable to accept Mr. Lacey as a patient presumably because of restrictions in their financing placed on them by their governing structures, almost all of a local, regional, state, or federal nature.

Our problem, and one that I hope our members will take to heart, is the need to respond to criticism of this type that is misdirected at the medical profession instead of at the governing and socialistic financing system that is fundamentally responsible in situations of this type.

In short, we shall ultimately get just about what we pay for, plus the cost of government.

William W. Moore, Jr., M.D.
Atlanta

References

1. Mosberg WH. Regionalization, cost containment, and rationing of health care. Neurosurg 1983;12(3):357.
2. Senator Robert Dole. Dole issues warning on health costs rises. AMA News, February 12, 1982, p 1.
3. Schwartz H. We need to ration medicine. Newsweek, February 8, 1982, p 13.
4. Whelan PJ. Blame socialist medicine in burn victim's case. The News American, June 30, 1982, p 15A.

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(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodal, mebutamate, or carbromal.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease within next 12-to-48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic®-M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbamal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS:
0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent.
3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.
10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur.
At levels greater than 20 mg percent, more fatalities than survivals can be expected.
Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.
In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.
Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets

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Summary of the Proceedings of the Medical Association of Georgia's 129th Annual Session

April 21-24, 1983, Columbus, Georgia

First General Session

Call to Order

The First General Session of the 129th Annual Session of the Medical Association of Georgia was called to order by the President, Charles D. Hollis, Jr., of Albany, at 7:00 PM in the Dining Gallery of the Columbus Convention and Trade Center. Dr. Hollis introduced the Reverend Dr. James Johnson of the First Presbyterian Church in Columbus. He delivered the invocation. The National Anthem and the Pledge of Allegiance were given by Dr. Cecil Whitaker of Columbus.

Deceased Members

Dr. Hollis then read the names of the MAG members who had died since the 1982 Annual Session. They were: E. B. Agnor, Atlanta; Edwin Allen, Sr., Milledgeville; Charles T. Brown, Buyton; Stewart D. Brown, Jr., Royston; R. L. Carter, Thomaston; Don F. Cathcart, Atlanta; John D. Deal, Statesboro; Thomas Bolling Gay, Atlanta; A. H. Germain, Atlanta; Howard A. Golden, Atlanta; J. Candler Guy, Atlanta; Clarence H. Harper, Folkston; A. Worth Hobby, Atlanta; O. F. Keen, Macon; James W. Knowlton, Toccoa; A. Beata Lobel, Tucker; Oscar H. Lott, Douglas; Frank S. MacDonnell, East Point; James Mashburn, Cumming; Charles E. MacArthur, Cordele; R. Roy McCollum, Jr., Kingsland; William E. McDavid, Riverdale; John Michaels, Tucker; W. Mercer Moncrief, Atlanta; William P. Nicolson, III, Atlanta; David M. Nowell, Dalton; Harry J. Portman, Savannah; C. R. A. Redmon, Savannah; Thomas L. Ross, Macon; W. L. Salter, Savannah; Harold M. Smith, Savannah; W. P. Stoner, Sylvester; William C. Warren, Jr., Atlanta; Seymour P. Weinberg, Atlanta; and John A. Wilhelm, Marietta.

Certificates of Appreciation

Dr. Hollis announced the following persons as recipients of Certificates of Appreciation for 1982-83: Stanley Aldridge, Decatur, Chairman, Committee on Drugs 1980-83; Charles Allard, Decatur, Chairman, Committee on Prison Health Care 1979-83; Thomas J. Anderson, Atlanta, Chairman, Committee on Health Planning, 1979-83; J. Dan Bateman, Albany, MAG Board of Directors 1968-83; H. Duane Blair, Decatur, Chairman, Committee on Cost Awareness 1977-83; F. William Dowda, Atlanta, AMA Delegate 1977-82; Lois T. Ellison, Augusta, Chairman Committee on Women Physicians in Organized Medicine 1979-83; Henry M. Finch, Atlanta, Chairman, Committee on Countersuit Review 1979-83; Evan L. Frederickson, Atlanta, Chairman, Committee on Crawford W. Long Memorial 1976-83; Richard Griffin, III, Cartersville, MAG Board of Directors 1977-81; Charles D. Hollis, Jr., Albany, MAG President 1982-83; Lillas L. James, Macon, Committee on Physician/Lawyer Liaison 1980-83; Henry S. Jennings, Jr., Gainesville,



Delegates from around the state attend MAG's 129th Annual Session in Columbus.

MAG Board of Directors 1980-83; Kenneth D. Jones, Augusta, Chairman, Committee on Mental Health 1978-83; Paul F. Jergensen, Savannah, Chairman, Committee on Medical Aspects of Sports 1978-83; Edward C. Loughlin, Atlanta, Chairman, Committee on Truthful Advertising 1981-83; James S. Mashburn, Cumming, Chairman, Committee on Disabled Doctors 1982; W. Frank Matthews, Decatur, Chairman, Committee on Transfusions and Transplantations 1974-83; Virgle W. McEver, Jr., Warner Robins, MAG First Vice-President, 1982-83; William W. Moore, Jr., Atlanta, Chairman, Committee on Professional Liability Insurance 1979-83; W. Perrin Nicolson, III, Atlanta, Chairman, Committee on Membership Insurance 1975-82; Jeffrey T. Nugent, Atlanta, Chairman, *Ad Hoc* Committee to Study Podiatric Education 1981-83; Jack A. Raines, Columbus, Chairman, MAG Board of Directors 1980-83; James Skinner, Griffin, MAG Board of Directors 1974-83; Joe C. Stubbs, Valdosta, Chairman, Committee on Foreign Medical Graduates, 1981-83; C. Rex Teeslink, Augusta, Chairman, MAG Committee on Scientific Assembly 1980-82; Mrs. David C. Thibodeaux, Marietta, President, Auxiliary to the MAG 1982-83; and William C. Waters, III, Atlanta, Chairman, Committee on *JMAG* Study 1981-83.

Fifty-year Certificates

Fifty-year Certificates were awarded to the following physicians: G. Darrell Ayer, Jr., Atlanta; Needham B. Bateman, Atlanta; M. B. Bowman, Albany; Dave Berman, Columbus; William R. Burdison, Augusta; A. H. Center, Savannah; A. B. Daniel, Statesboro; Clarence D. Fowler, Atlanta; I. S. Giddens, Lakeland; Wadley R. Glenn, Atlanta; Harry T. Harper, Augusta; William A. Kelley, Atlanta; Robert E. Leonard, Augusta; John M. McGehee, Cedartown; Arthur J. Merrill, Sr., Atlanta; Joyce F. Mixson, Jr., Valdosta; R. L. Oliver, Savannah; Rufus F. Payne, Augusta; John T. Persall, Jr., Augusta; Fred F. Ruder, Atlanta; Harry E. Talmadge, Athens; Thomas B. Taylor, Douglasville; Frank E. Thomas, Seminole, Florida; and Allan G. Thurmond, Augusta.

Life Members

Dr. Hollis then announced that the following members had been awarded Life Membership in the Medical Association of Georgia: Rudolf A. Colmers, Savannah; A. B. Daniel, Statesboro; W. Raleigh Garner, Gainesville; Oliver T. Ghent, Gainesville; W. D. Hazelhurst, Macon; W. D. Jarratt, Macon; Hartwell Joiner, Gainesville; J. M. Kellum, Thomaston; A. J. Mooney, Statesboro; E. F. Rosen, Savannah; Eugene Ward, Gainesville; and C. W. Whitworth, Gainesville.

At the conclusion of the presentation of these awards, Dr. Hollis introduced the Honorable J. W. Feighner, Mayor of the City of Columbus, who extended official greetings from the city.

Then Dr. William C. T. Jernigan, President of the Muscogee County Medical Society, extended greetings on behalf of the Society to the MAG Assembly.

Dr. Hollis introduced Mrs. David Thibodeaux, President of the Auxiliary to the MAG, who gave a brief report on the activities and accomplishments of the Auxiliary during the past year. She then introduced a special guest of the Auxiliary, Mrs. Martha Hughes, President of the Southern Medical Association. Mrs. Hughes extended greetings from SMA.

AMA-ERF Checks

Mrs. Thibodeaux and Mrs. Fay Isele then presented AMA-ERF checks as follows:

Medical College of Georgia $10,361.70;
Emory University School of Medicine $12,487.32;
School of Medicine at Morehouse College $2,378.70;
Mercer University School of Medicine $2,309.73.

Adjournment

Following several brief announcements, Dr. Hollis adjourned the First General Session at 7:10 PM.

First Session — House of Delegates

Thursday, April 21, 1983

The First Session of the MAG House of Delegates was called to order by the Speaker of the House, Jack Menendez, of Macon, at 8:15 PM Thursday, April 21, 1983, in the Dining Gallery of the Columbus Convention and Trade Center, Columbus, Georgia. James A. Kaufmann of Atlanta served as Vice-Speaker of the House.

The Speaker called for a report from the Credentials Committee which was given by Dr. Milton I. Johnson, Jr. He reported 113 duly elected Delegates representing 31 component medical societies in attendance and accordingly announced a quorum of the House was present.

Attendance

Delegates: Donald C. Abele, E. Q. Abellera, Stanley P. Aldridge, Joseph M. Almand, Jr., Thomas J. Anderson, Jr., Harold Asher, John F. Atha, Sam O. Atkins, Joseph P. Bailey, William E. Barfield, Sr., J. Dan Bateman, John G. Bates, James F. Beattie, Jr., Linton H. Bishop, Jr., H. Duane Blair, Neil D. Boggess, Jr., C. Emory Bohler, Stephen Boyle, Robert G. Bradbury, Rupert H. Bramblett, Spencer S. Brewer, Jr., William P. Brooks, Rodney M. Browne, L. C. Buchanan, Leon H. Bush, Joseph G. Bussey, Jr., Betty Wray, Georgia M. Chastain, Joseph T. Christmas, Alvin H. Clair, S. William Clark, Jr., Thurman Clemons, Marvyn D. Cohen, Richard W. Cohen, Chappell A. Collins, Jr., William C. Collins, Lanny R. Copeland, John W. Darden, Dave M. Davis, Floyd E. Davis, H. G. Davis, Jr., J. H. Deaton, Sammie Dixon, F. William Dowda, Richard E. Dubois, A. G. Dudley, James C. Dudley, E. C. Evans, James P. Evans, Louis H. Felder, Robert F. Finegan, Sumner Fishbein, Henry A. Foster, Milton Frank, III, Norman P. Gardner, Cyler Garner, James S. Goodlet, H. Hilt Hammett, Jr., Kelvin Lane, William R. Hardcastle, Charles E. Harrison, Jr., J. Harold Harrison, J. Rhodes Haverty, William McKendree Headley, John P. Heard, Irving D. Hellenga, Kenneth C. Henderson, E. V. Herrin, William E. Holladay, William C. Holmes, John B. Hunt, Philip Z. Israel, Joseph M. Jackson, William C. T. Jernigan, C. E. Johnson, Jr., Milton I. Johnson, Jr., Fleming L. Jolley, William B. Jones, W. Dan Jordan, James A. Kaufmann, Garland E. Kinard, Luella M. Klein, Gregory B. Knowlton, C. Peter Lampros, Charles A. Lanford, Bob G. Lanier, William A. Lardin, J. Moultrie Lee, Robert A. Lipson, William D. Logan, Jr., David A. Wells, Lawrence E. Lykins, Raymundo T. Mallari, Donald H. Manning, Johann R. Manning, Kenneth Goldman, John D. Watson, Alva L. Mayes, Jr., J. Kenneth McDonald, Charles W. McDowell, Jr., Virgle W. McEver, Jr., LaMar S. McGinnis, Ray L. McKinney, Frank W. McKinnon, Jack F. Menendez, Frank F. Middleton, III, Cecil L. Miller, Edmund M. Molnar, William W. Moore, Jr., Christian R. Moorhead, Hugo S. Moreno, Toby Morgan, A. J. Morris, Larry A. Morris, Gerald B. Muller, Spencer G. Mullins, A. D. Muse, Jr., James Robert Neill, Joe L. Nettles, Bruce C. Newsom, John S. Newton, Jeffrey T. Nugent, Robert W. Oliver, Jr., Harry Porter, Jr., Quenton Price, Robert B. Quattlebaum, Jr., J. B. Rabun, Jack A. Raines, Walker L. Ray, John E. Roberts, Harrison L. Rogers, Jr., Ronald P. Roper, Clyde B. Rountree, Dan Hankey, Virendra M. Saxena, Eric C. Segerberg, Eloise B. Sherman, Robert W. Simmons, Barry D. Silverman, James M. Skinner, William H. Biggers, Edward H. Smith, Jr., George L. Smith, James L. Ray, Rodney L. Smith, Thomas H. Smith, Jr., David S. Sowell, Robert J. Starling, Dan B. Stephens, William Rawls, James H. Sullivan, Roland S. Summers, Luther M. Thomas, Tom Marks, Hugh S. Thompson, Jr., Ralph A. Tillman, James H. Tison, Charles E. Todd, Jr., L. Newton Turk, III, J. R. Turner, Charles R. Underwood, Theodora Vanderzalm, Roy W. Vandiver, Minor C. Vernon, Emmerich Von Hamm, Jr., Edward Jones Waits, R. D. Walter R. Voyles, Lamar H. Waters, Alexander H. S. Weaver, Robert E. Wells, William H. Whaley, Richard A. Wherry, James Q. Whitaker, Dan H. Willoughby, J. S. Wilson, Stephen A. Wohlgemuth, William A. Wolff, Charles H. Wray, James Thomas Yauger, Neal F. Yeomans.



Jack Menendez, of Macon, served as Speaker of the House.

Alternate Delegates: C. Emory Bohler, Harris Deitz Carpenter, Jr., Carl L. Crawford, Leon E. Curry, William B. Dewberry, Harry N. Dorsey, M. Julian Duttera, Jr., William C. Flanagan, Jr., John R. Grant, Anthony F. Isele, G. A. Johnson, Georgia R. Jones, Robert M. Patton, G. V. Raghu, Fred M. Rankin, Michael H. Roberts, David C. Thibodeaux, James A. Walker.

Appointment of Committees

The Speaker announced the appointment of the House of Delegates Reference Committees, Credentials Committee, and Tellers Committee as follows:

Reference Committee on Constitution & Bylaws: Bruce Newsom, Columbus, Chairman; Richard Cohen, Austell, Vice-Chairman; Barry Silverman, Atlanta; Floyd Davis, Waycross; Ken Henderson, Macon; J. R. Turner, LaGrange; Don Abele, Augusta; Gordon Davis, Sylvester.

Reference Committee A: LaMar S. McGinnis, Decatur, Chairman; Ray L. McKenney, Albany, Vice-Chairman; James P. Evans, Savannah; Alva L. Mays, Jr., Macon; Joseph Almand, LaGrange; Ronald Roper, Marietta; Joe Wilson, Atlanta; Cecil Miller, Buford.

Reference Committee B: Charles Harrison, Atlanta, Chairman; Rodney Browne, Macon, Vice-Chairman; Dan Stephens, Marietta, O. Wytch Stubbs, Tucker; Carl Hancock, Albany; Neil Yeomans, Waycross; Edmund Molnar, Columbus; Roland Summers, Savannah.

Reference Committee C: Phil Israel, Marietta, Chairman; Robert Bradbury, Savannah, Vice-Chairman; Frank Wilson, Atlanta; Charles Lanford, Macon; Ralph Tillman, Decatur; Toby Morgan, Rome; A. D. Muse, Athens; William Kent, Statesboro.

Reference Committee D: Alexander H. S. Weaver, Macon, Chairman; Louis Felder, Atlanta, Vice-Chairman; Walter R. Voyles, Waynesboro; Roy W. Vandiver, Decatur; Dan H. Willoughby, Savannah; William H. Wolf, Columbus; Thurmond Clemons, Statesboro; Edward H. Smith, Jr., Augusta.

Reference Committee F: Cyler D. Garner, Gordon, Chairman; C. Peter Lampros, Toccoa, Vice-Chairman; C. Emory Johnson, Macon; A. J. Morris, Vidalia; Luther Thomas, Augusta; Jeffrey T. Nugent, Atlanta; Marvyn Cohen, Columbus.

Tellers Committee: Joseph Christmas, Vienna, Chairman; Robert Quattlebaum, Savannah; Minor Vernon, Macon; John Atha, Rockmart.

Credentials Committee: Milton I. Johnson, Jr., Macon, Chairman; Walker L. Ray, Clarkston.

Parliamentarian: Jack A. Raines, Columbus.

Adoption of Minutes

On motion duly made and seconded, it was voted that the Proceedings of the 1982 Meeting of the MAG House of Delegates as published in the special Supplement of the *Journal* of the MAG dated June 1982 be approved as published.

Nominations

Speaker Menendez called on the House to proceed with nominations for the Officers, AMA Delegates, Alternate Delegates, and Judicial Council. The following nominations were made:

President-Elect: Rupert H. Bramblett, Cumming, was nominated for President-Elect by Cecil Miller with seconding nominations by J. Harold Harrison, Jack Raines, and Milton I. Johnson.

S. William Clark, Waycross, was nominated for President-Elect by Floyd Davis and seconded by Charles Underwood, Joe Bailey, and Charles Harrison.

Virgle W. McEver, Warner Robins, was nominated for President-Elect by Beverly Sanders, and seconded by Tom Anderson, Harrison L. Rogers, James Skinner, and Pat Evans.

Second Vice-President: John D. Watson, Columbus, was nominated for the office of Second Vice-President by Jack Raines with a voice second from the floor.

Speaker of the House: Jack Menendez, Macon, was nominated for Speaker of the House by C. Emory Bohler, with a voice second from the floor.

Vice-Speaker of the House: James A. Kaufmann, of Atlanta, was nominated by Bob Lanier with a voice second from the floor.

Judicial Council: Speaker Menendez announced the nominations made for this Office by President Charles Hollis as follows: Robert Copeland, LaGrange, for a second 5-year term, and C. Emory Bohler, Brooklet, for a 2-year term to fill the unexpired term of John D. Watson.

AMA Delegates: C. Emory Bohler, Brooklet, was nominated by Thurmond Clemons, with a voice second from the floor; H. Hilt Hammett, Jr., LaGrange, was nominated by Joe Almand with a voice second from the floor; William W. Moore, Jr., Atlanta, was nominated by J. Harold Harrison with a voice second from the floor; and Charles D. Hollis, Jr., Albany, was nominated by Frank Middleton with a voice second from the floor.

There being no additional nominations, the nominations were closed.

AMA Alternate Delegates: Carson B. Burgstiner, Savannah, was nominated by John Raybun; S. Wm. Clark, Waycross, was nominated by H. Hilt Hammett; C. Peter Lampros, Toccoa, was nominated by Charles Lanford; L. Newton Turk, III, Atlanta, was nominated by Jeffrey Nugent; James H. Sullivan, Columbus, was nominated by Charles D. Hollis.

There being no additional nominations, the nominations were closed.

Election of Unopposed Candidates by Voice Vote

Speaker Menendez asked if there were any intentions to mount a write-in campaign for any of the AMA officials previously nominated. Hearing that no such campaigns were anticipated, the Speaker declared all of the unopposed candidates for Speaker, Vice-Speaker, Second Vice-President, AMA Delegates and AMA Alternate Delegates to be duly elected.

Directors and Alternate Directors

Dr. Menendez announced the results of the elections for Directors and Alternate Directors as conducted by the District Medical Societies and Component County Medical Societies:

Sixth District Medical Society:
Director: Samuel W. Brewton, Jr., Thomaston (1986)
Alternate Director: Norman P. Gardner, Thomaston (1986)

Seventh District Medical Society:
Director: Bannester L. Harbin, Jr., Rome (1986)
Alternate Director: John F. Atha, Rockmart (1986)

Dougherty County Medical Society:
Director: Frank F. Middleton, III, Albany (1986)
Alternate Director: Carl D. Hancock, Jr., Albany (1986)

Hall County Medical Society:
Director: John H. Reed, Jr., Gainesville (1986)
Alternate Director: James H. Leigh, Gainesville (1986)

Medical Association of Atlanta:
Director: William C. Collins, Atlanta (1986)
Alternate Director: Bob G. Lanier, Atlanta (1986)

Muscogee County Medical Society:
Director: Jack A. Raines, Columbus (1986)
Alternate Director: E. M. Molnar, Columbus (1986)

Annual Reports

Speaker Menendez called for the Annual Reports of the MAG Officers, Directors, Committees, Departments, and other reports to be introduced at this Session which are listed below with the Reference Committee to which these reports were referred.

Officers' Reports

President — A
Immediate Past President — Not Referred
First Vice-President — A
Secretary — Not Referred
Treasurer — F
Speaker of the House — Constitution and Bylaws
Chairman of the Board — Not Referred
Board of Directors Report A — A
Board of Directors Report B — F
Board of Directors Report C — C
Board of Directors Report D — C

Directors' Reports

First District Society — Not Referred
Second District Society — Not Referred
Third District Society — Not Referred
DeKalb Medical Society — Not Referred
Medical Association of Atlanta — Not Referred
Sixth District Society — Not Referred
Seventh District Society — Not Referred
Eighth District Society — Not Referred
Ninth District Society — Not Referred
Tenth District Society — Not Referred
Bibb County Society — Not Referred
Georgia Medical Society — Not Referred
Crawford W. Long Medical Society — Not Referred
Cobb Medical Society — A
Dougherty County Society — Not Referred
Floyd-Polk-Chatooga Society — Not Referred
Hall County Society — Not Referred
Muscogee County Society — Not Referred
Richmond County Medical Society — Not Referred

Committee Reports

Access to Health Care — A
Auxiliary — Not Referred
Building and Land — Not Referred
Cancer and Cancer Advisory Sub-Committee — Not Referred
Constitution & Bylaws — Constitution & Bylaws
Cost Awareness — Not Referred
Crawford W. Long Memorial — Not Referred
Drug — Not Referred
Education — Not Referred
Emergency Medical Services — Not Referred
Foreign Medical Graduates — Not Referred
Health Planning — C
Impaired Physicians — A
Journal — Not Referred
Legislation — Not Referred
Maternal & Infant Health — Not Referred
Medical Practice — B
Medical Practice Supplemental — B
Medicine & Human Values — C
Membership — A
Nursing — Not Referred
Physicians' Assistants — D
Physician/Lawyer Liaison — A
Prison Health Care — Not Referred
Public Health — Not Referred
Public Relations — A
Risk Management — A
Scientific Assembly — Not Referred
Talmadge Hospital Liaison — Not Referred



Thurman Clemons (left), C. Emory Bohler, and J. Rhodes Haverty are among those participating in the business of the House.

Third Party Relations — B
Transfusions & Transplantations — Not Referred
Ad Hoc Committee on Specialty Society Representation and Supplemental — D

Special Reports

Auxiliary — Not Referred
MAG Mutual Insurance Company — Not Referred
Georgia Medical Care Foundation — Not Referred

New Business

The Speaker proceeded to new business by calling for the introduction of Resolutions (Res.) which were assigned to Reference Committees as follows:

Res. 1: JCAH Medical Staff Definition — B
Res. 2: Bylaws Change — Annual Session House of Delegates Meeting — C & B
Res. 3: Informed Consent Legislation — C
Res. 4: Free Standing Medical Clinics — B
Res. 5: Business/Medicine Coalition — B
Res. 6: Preferred Provider Organizations — B
Res. 7: Informed Consent Legislation — C
Res. 8: Revision of JCAH Medical Staff — B
Res. 9: JCAH Proposed Revisions to the Accreditation Manual for Hospitals; Organized Medical Staff vs. Organized Staff — B
Res. 10: Cost of Medical Care — B
Res. 11: Hospital Staff Privileges — D
Res. 12: Freedom of Choice — Workman's Compensation — C
Res. 13: JCAH Standards — B
Res. 14: Preferred Provider Organizations — B
Res. 15: Conference on Training Future Physicians for the Competitive Market Place — A
Res. 16: House Bill 528 — C
Res. 17: Usual, Customary, and Reasonable Fees — C
Res. 18: Definition of Private Practice of Medicine — C
Res. 19: Federal Trade Commission — D
Res. 20: Access to Medical Care — A
Res. 21: MAG Membership Recruitment for Use of MAG Staff Outreach Program — A
Res. 23: Hospital Medical Staff Section — D
Res. 24: AMA Dues Increase — F
Res. 25: Slotted Seat for Residents and Students on AMA Board of Trustees — C

Following several announcements by the Speaker, the First Session of the House of Delegates was adjourned at 9:20 PM.

VALLEY PSYCHIATRIC HOSPITAL

SOME THINGS WE'D LIKE YOU TO KNOW...

- VALLEY PSYCHIATRIC HOSPITAL IS A PRIVATE TREATMENT FACILITY DESIGNED TO TREAT PSYCHOLOGICAL/EMOTIONAL, ALCOHOL AND DRUG ABUSE PROBLEMS AND IS COMMITTED TO PROVIDE THE BEST CARE AND TREATMENT AT AN AFFORDABLE COST.
- VALLEY HOSPITAL HAS 100 LICENSED BEDS AND IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.
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Second Session — House of Delegates

Saturday, April 23, 1983

The Second Session of the MAG House of Delegates was called to order at 9:00 AM, Saturday, April 23, 1983, in the Dining Gallery of the Columbus Convention and Trade Center, by Speaker Jack Menendez.

Dr. Menendez presented Certificates of Appreciation for outstanding legislative work to Senator Richard Greene, Representative Bobby Phillips, and Representative Calvin Smyre.

Dr. Charles Hollis, President of MAG, then introduced Dr. James H. Sammons, Executive Vice-President of the American Medical Association, for an address to the House of Delegates.

Following Dr. Sammons address, the Speaker asked for a report from the Credentials Committee which was given by Milton I. Johnson, of Macon. Dr. Johnson reported 169 Delegates present, representing 39 county medical societies and announced, accordingly, that a quorum was present.

Reference Committee Reports

Speaker Menendez called for reports from the Reference Committee Chairmen.

Announcement of Election Results

The Speaker announced the results of the elections as follows:

President-Elect — S. William Clark, Jr., Waycross
Second Vice-President — John D. Watson, Columbus
Judicial Council (To fill unexpired term of John Watson) — C. Emory Bohler, Brooklet; and for a new 5-year term, Robert Copeland, LaGrange.
AMA Delegate — C. Emory Bohler, Brooklet
AMA Delegate — H. Hilt Hammett, Jr., LaGrange
AMA Delegate — William W. Moore, Jr., Atlanta
AMA Delegate — Charles D. Hollis, Jr., Albany
AMA Alternate Delegate — C. Peter Lampros, Toccoa
AMA Alternate Delegate — L. Newton Turk, III, Atlanta
AMA Alternate Delegate — S. William Clark, Jr., Waycross
AMA Alternate Delegate — Carson B. Burgstiner, Savannah

New Business

Under unanimous consent, Delegate H. Hilt Hammett, Jr., moved that the minutes reflect the expertise demonstrated by Speaker Menendez and Vice-Speaker Kaufmann as they presided over the activities of the MAG House of Delegates. The motion was adopted.



James A. Kaufmann (center) conducts House business as Vice-Speaker.



S. William Clark, Jr. (center), and Floyd E. Davis (right) attend the House. Dr. Clark was elected President-Elect of the MAG.

Adjournment

There being no further business before the House of Delegates, the Speaker adjourned the Second Session of the House at 5:20 PM.

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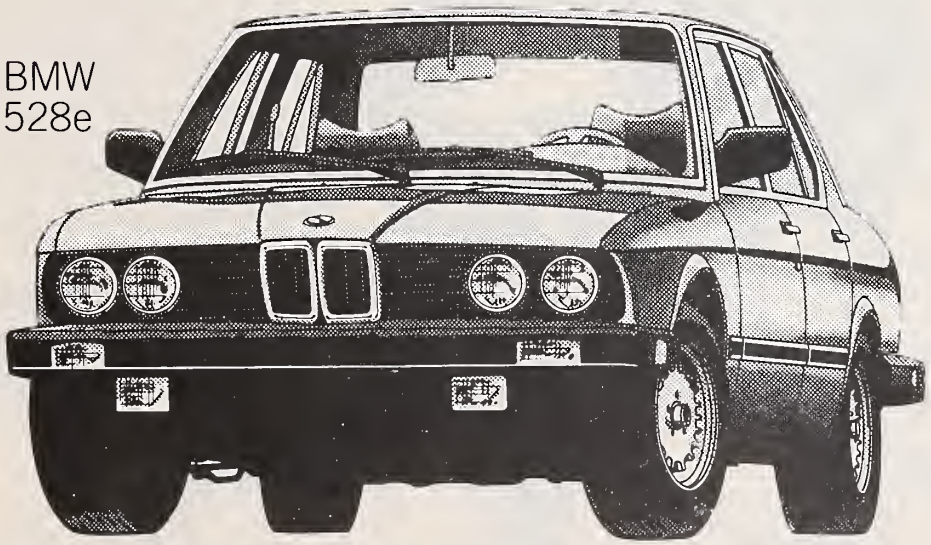
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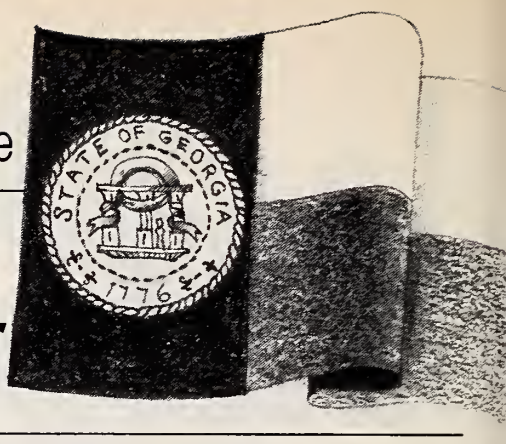
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Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

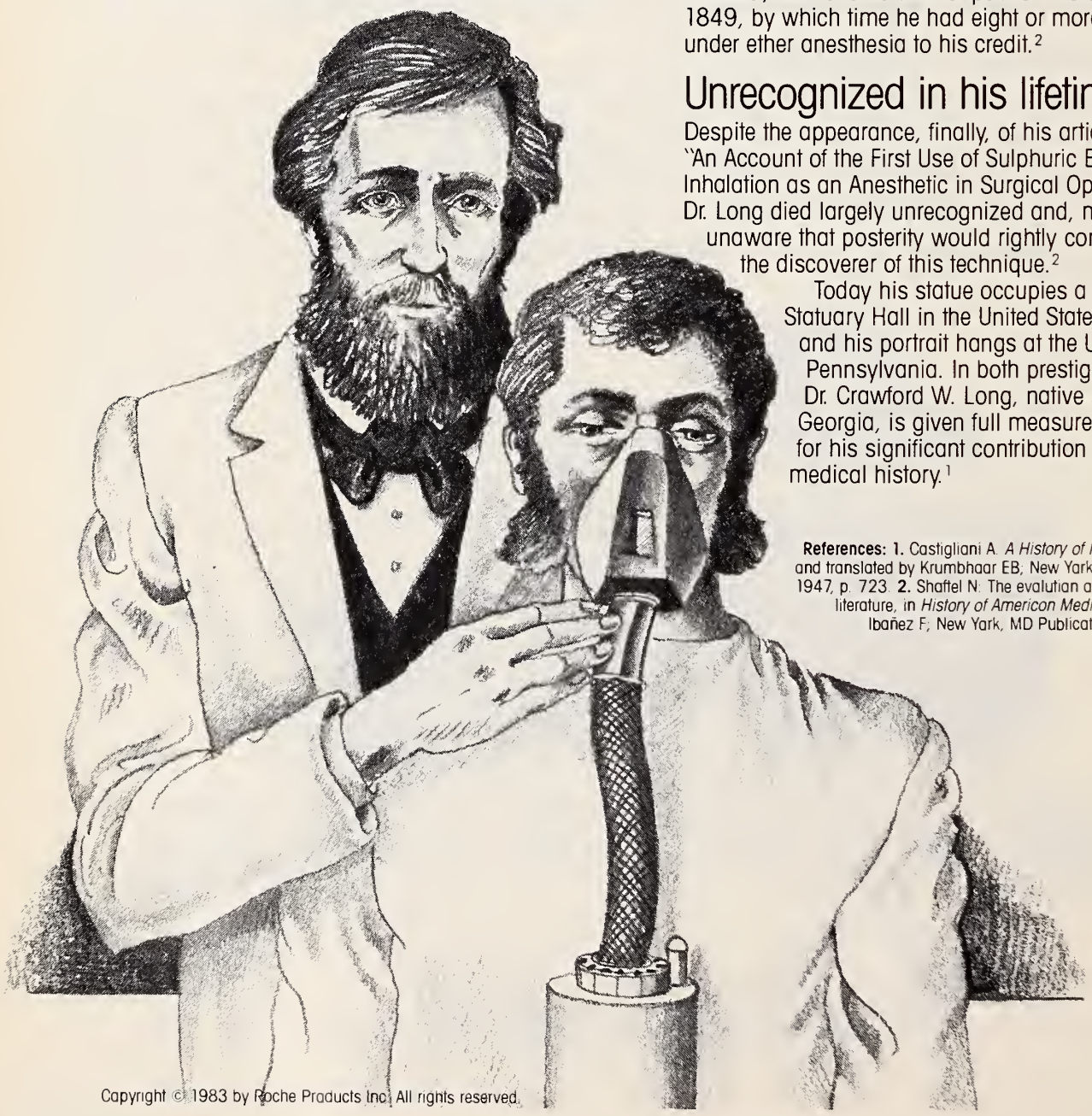
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Castigliani A. *A History of Medicine*, edited and translated by Krumbhaar EB, New York, Alfred A. Knapf, 1947, p. 723. **2.** Shaftel N: The evalution of American medical literature, in *History of Americon Medicine*, edited by Marti-Ibañez F, New York, MD Publicatians, 1959, p. 107.

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Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.[2]

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- ☐ Headache—79%
- ☐ Early insomnia—91%
 Middle insomnia—87%
 Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.[3]

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treotment of onxiety, in *Psychapharmacalogy in the Practice af Medicine,* edited by Jorvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychapharmacalogy 61:* 217-229, Mor 1979. **3.** Data on file, Hoffmann-Lo Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol® 5/12.5 10/25

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Please see summary of product information on following page.

LIMBITROL® TABLETS Ⓥ Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Report of Reference Committee on Constitution and Bylaws

Bruce Newsom, M.D., Chairman
Richard W. Cohen, M.D., Vice-Chairman

The Chairman reported to the House of Delegates that the reports and resolutions referred to Reference Committee on Constitutions and Bylaws, which met on April 22, 1983, were carefully considered. The members of the committee were Bruce Newsome, Chairman, Columbus; Richard W. Cohen, Austell, vice-chairman; Barry Silverman, Atlanta; Floyd Davis, Waycross; Ken Henderson, Macon; J. R. Turner, LaGrange; Don Abele, Augusta; and Gordon Davis, Sylvester.

Constitution and Bylaws Committee

J. Rhodes Haverty, M.D., Chairman

Your Constitution and Bylaws Committee has met several times during the past year to discuss several proposed amendments to the Constitution and Bylaws which were directed to us. We now present these amendments for your action.

The first items presented will be amendments to the Constitution which have either lain on the table for one year or must lie on the table for one year.

Constitutional Amendments

The following amendment, introduced during the 1982 House of Delegates, has lain on the table for one year and is presented to you for action:

Article V — House of Delegates, Section 1, Composition. (Note: new language will be underlined.)

The House of Delegates is composed of delegates elected by the component county medical societies, the House Officers Section, and Georgia Medical Schools as provided in the Bylaws.

We have been directed by the MAG Board of Directors to further amend this Article to allow delegates from the Medical Staff Section and specialty society delegates to be seated as voting members in the House; therefore, we present the following amendment which must lie on the table for one year:

Amend Article V, Section 1

(Note — if you so approve the Constitutional amendment before you for action, the new amendment will be as follows:)

* The House of Delegates is composed of delegates elected by the component county medical societies, the House Officers Section, Georgia Medical Schools, Medical Staff Section, and delegates elected by specialty societies which are represented on MAG's Interspecialty Council ~~as provided for in the Bylaws~~. All delegates' qualifications and terms of office shall be provided for in the Bylaws.

* No action may be taken on this amendment until the 1984 House of Delegates, as it must lie on the table for one year.

House Action

Adopted.

We now present for your action amendments to the Bylaws. Note that any deletions will appear with lines ~~stricken~~ through them and proposed language will appear with underlines.

Bylaws Amendments

Chapter II, Section 2, Retired Members (define):

AMA now has made available to retired members exemption from dues if they work less than 20 hours per week. In order for MAG Bylaws not to conflict with AMA, we should amend our Bylaws accordingly. We would amend by addition of a third sentence, "Retired physicians shall be defined as those who have indicated their retirement to MAG and practice less than 20 hours per week."

House Action

Adopted.

Chapter II, Section 8, Student Members:

The MAG Board of Directors approved a recommendation of the Membership Committee to amend the Bylaws in order to attract medical students to organized medicine and give to them some rights and privileges. We would amend by deletion and addition:

Delete the second sentence, "~~Student members shall not be required to pay dues~~ . . ." and substitute the following: Student members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees.

If approved, this amendment would allow students to receive the *Journal of the Medical Association of Georgia*, the *Newsletter*, and allow MAG to place a small administrative fee on the student members to help offset the cost of *JMAG*, *Newsletter*, and storing their names in the computer.

House Action

Adopted.

Chapter II, Section 12, Transfer:

Some physicians are calling to headquarters that they are transferring to another society, then calling back later after transfer has been made stating that they did not call to transfer. Therefore, we feel these transfers should be submitted in writing from the county medical society to which the member is transferring.

We would amend by the addition of a second sentence, "All transfers of membership from one county medical society in the State to another county medical society shall be forwarded in writing to MAG from the member's new county medical society before the transfer will be finalized."

House Action

Adopted.

Chapter IV, Section 2, Composition (House of Delegates), second paragraph:

As there are now more than two medical schools in Georgia, we need to amend this section to accommodate the others. We would amend by deletion and addition the following:

"One student representative each from the ~~Emory Medical School and Medical College of Georgia Chapters of the American Medical Student Association . . .~~" "medical schools in Georgia which are accredited by the Liaison Committee on Medical Education shall be. . . ."

House Action

Adopted.

As we have an amendment to Article V of the Constitution before us to give House Officers (residents) a voting delegate in the House, which, if passed, would also need to be in the Bylaws, we would offer the following amendment to Chapter IV, Section 2, as a third paragraph:

"The House Officers Section shall be entitled to one voting delegate and alternate delegate. These delegates shall be elected by the Section and shall be members in good standing with the MAG."

We will of course offer a further amendment to this section next year to include the medical staff section and the specialty society delegates in light of the proposed amendment to Article V of the Constitution which must lie on the table until 1984.

House Action

Adopted.

Chapter VIII, Section 3, Charter:

"The charter of any component county shall stand automatically revoked as of February 1 of the next calendar year following 12 consecutive full calendar months when ~~the total dues forwarded by the secretary of the particular component county medical society to the Association~~ received by the Association shall constitute the dues. . . ."

As we have been on central billing for several years, this method of dues forwarding is obsolete.

House Action

Adopted the following substitute amendment: "The Charter of any component county medical society shall stand automatically revoked as of February 1st of the next calendar year following twelve consecutive calendar months when the total dues forwarded to the Association shall total less than five members. . . ."

Chapter VIII, Section 11, District Societies:

MAG membership department reports that physicians are trying to join the District Medical Societies without being a member of the county medical societies and MAG. As many actions are taken at the district level which affect MAG, especially the elections of directors and alternate directors, we feel that it is not fair for nonmembers to have the same privileges offered to members; we therefore offer the following amendment by addition of another sentence to the first paragraph:

"All district society members shall be members in good standing with their county medical society and the MAG."

House Action

Adopted.

Chapter IX, Section 2, (c), Dues and Assessments:

MAG membership department reports that members who are dues delinquent for only one year are complaining about having to fill out another membership application and having it approved. Several county medical societies have also complained about this. The MAG would like to accept these without reapplication. They would do so by asking the county medical society involved if it has no objection, John Doe, MD, has submitted his dues and will be reinstated.

Therefore, we would amend by deletion and substitution the following:

An active member who fails to pay dues (or additional dues) for one ~~or more years shall be eligible for reinstatement upon payment of dues for the current year subject to reapplication to and approval of the respective county medical society~~ year may be reinstated without reapplication upon payment of dues, provided there is no objection by the respective county medical society. Any member failing to pay dues (or additional dues) for more than one year shall be eligible for reinstatement upon payment of dues for the current year, subject to reapplication to and approval of the respective county medical society."

House Action

Adopted the amendment by further amending the original as follows: "An active member who fails to pay dues for one year may be reinstated without reapplication upon payment of the current and past year's dues, provided there is no objection by the respective county medical society. Any member failing to pay dues for more than one year shall be eligible for reinstatement upon payment of dues for the current year, subject to reapplication to and approval of the respective county medical society."

Your Committee wishes to bring to your attention an opinion rendered by MAG's Judicial Council regarding the seventy-five day amendment rule in the Bylaws, Chapter XV — Amendments. As several questions had been raised about further amending the Bylaws after they had been presented to the House, your Committee felt that in all fairness we should have an official interpretation on this Section. The opinion is as follows:

Opinion of the Judicial Council of the Medical Association of Georgia — Topic: Bylaws Changes

As pertains to Bylaws changes to be considered by the House of Delegates of the Medical Association of Georgia, the current Bylaws require proposed changes in the Bylaws to be submitted at least 75 days prior to the annual meeting.

It is the opinion of the Judicial Council of the Medical Association of Georgia that the intent of this principle is to allow the Bylaws Committee of the MAG time to study the proposed changes and, in their opinion, determine acceptance, rejection, discovery, conflict with existing Bylaws, and consequence of change. This process also allows notification of the membership of "potential" change.

Upon appropriate submission of a proposed change, it is the prerogative of the House of Delegates or its designated committees, etc., to offer amendments or other

modifications to such proposal(s) at the time of the annual meeting. In view of the importance of such modifications to the Bylaws, it is considered appropriate by this Council that such considerations be made known to the component societies of the MAG in a timely fashion. The notification of component societies is recommended out of respect and consideration more than due process. Any modification of the originally proposed change in the Bylaws must restrict itself to the section(s) and subject as addressed by the original proposal.

If modification of the proposed change, i.e., reference committee, amendments from the floor, required the usual 75 days notice to the House, the mechanism would defeat the current concept of change and render the House of Delegates unable to adapt to the demands of "timely" action. It is the opinion of the Judicial Council that this type of legislative obstructionism was not the intent of "Lying on the Table" for 75 days for the original proposal. Rather the intent was designed for the communication of the intent, anticipating potential modification at the time of the annual meeting of the MAG, and consideration by the House of Delegates of the final form of the proposal.

John D. Watson, MD
Secretary
MAG Judicial Council

Speaker of the House

Jack F. Menendez, M.D.

Thank you for allowing me to serve you as Speaker of the House of the Medical Association of Georgia. Without your help, the job of Speaker would be very difficult indeed. With the excellent professional delegations we have had over the past years, we have been able to arrive at some difficult decisions with relative ease and excellence.

With the able assistance of Dr. James Kaufmann, Vice Speaker, and by adopting the AMA Format for presenting reference committee reports, we have been able to place the emphasis on discussion of the various resolutions and reports presented to us in the Reference Committees, where it belongs. I believe this is the key factor in allowing us to shorten the time spent in discussion on the floor of the House of Delegates. We have some remaining technical problems with rapidly dealing with floor amendments but we are continuing to work on a solution for this, and this year we are going to introduce a computerized method for projecting amendments. Hopefully this will make them rapidly legible to everyone.

An essential part of the Speaker's job is preparation. Indeed, preparation is the secret of a smoothly run House of Delegates Session. As I have attempted to evaluate various places where we hold our Annual Session, certain common elements have become clear.

The hotel should be adequate in size to house the entire Medical Association delegation and the Medical Auxiliary delegation. It is also important that the meeting rooms necessary for both of these organizations to function be available under one roof. This requires a hotel with approximately 250 rooms if we are meeting outside of Atlanta, and approximately 175 rooms if we meet in the Atlanta area. At the present time there are only 3 locations in the state that meet this qualification; they are Atlanta, Savannah, and Callaway Gardens. When we meet in an area where the Medical Association delegation is divided, or the Auxiliary is divided, and the meeting places are not under one roof, it causes transportation problems and budgetary problems, in that we have to pay for additional meeting space.

As a result of the foregoing factors, I would like to make the following

Recommendations

1. That the MAG Board of Directors continue to carefully select the sites for the Annual Session.
2. The above mentioned factors be presented by staff to the Board of Directors and be included in their discussion of Annual Session sites.

House Action

Adopted Recommendation 1.

Did not adopt Recommendation 2 as submitted but adopted the following in lieu of it: that the Board of Directors give serious consideration to the physical and fiscal aspects of any proposed annual meeting site, and further, that the Board of Directors give due respect for any wishes of the House of Delegates in this regard.

Resolution 2

Bylaws Change — Annual Session House of Delegates Meeting

Rupert H. Bramblett, M.D., Delegate
Gwinnett-Forsyth County Medical Society

RESOLVED, that Article IX, Section 1, of the Constitution of the Medical Association of Georgia be amended by deletion of the words "Board of Directors" and the substitution of the words "House of Delegates," and that Article IX, Section 2, be amended by deletion of the words "Board of Directors" and the substitution of the words "House of Delegates." Upon adoption of said amendments, Article IX, Section 1, shall read as follows:

SECTION 1. ANNUAL SESSION. The Association shall hold an Annual Session at a time and place fixed by the House of Delegates.

SECTION 2. HOUSE OF DELEGATES. The House of Delegates shall meet during the Annual Session and in interim sessions as may be determined by the House of Delegates,

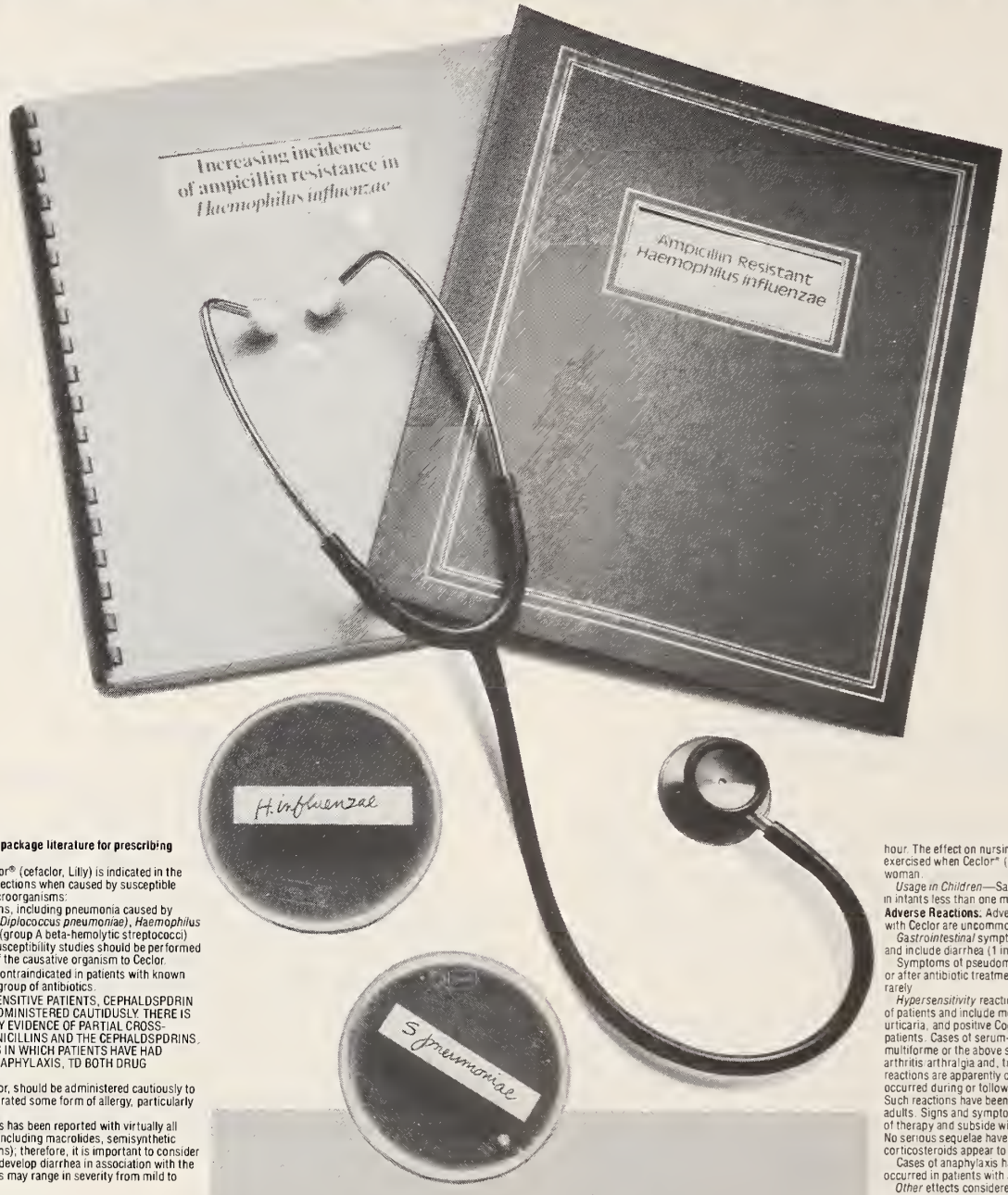
and be it further

RESOLVED, that MAG House of Delegates instruct the MAG's Constitution and Bylaws Committee to present amendments to the 1984 House of Delegates which, upon adoption, would accomplish the changes herein provided.

House Action

Did not adopt.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALDSPDRIN ANTIBIDTICS SHDULD BE ADMINISTERED CAUTIDUSLY. THERE IS CLINICAL AND LABDRATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALDSPDRINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIDNS, INCLUDING ANAPHYLAXIS, TD BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Dther causes ot colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use ot Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction tor glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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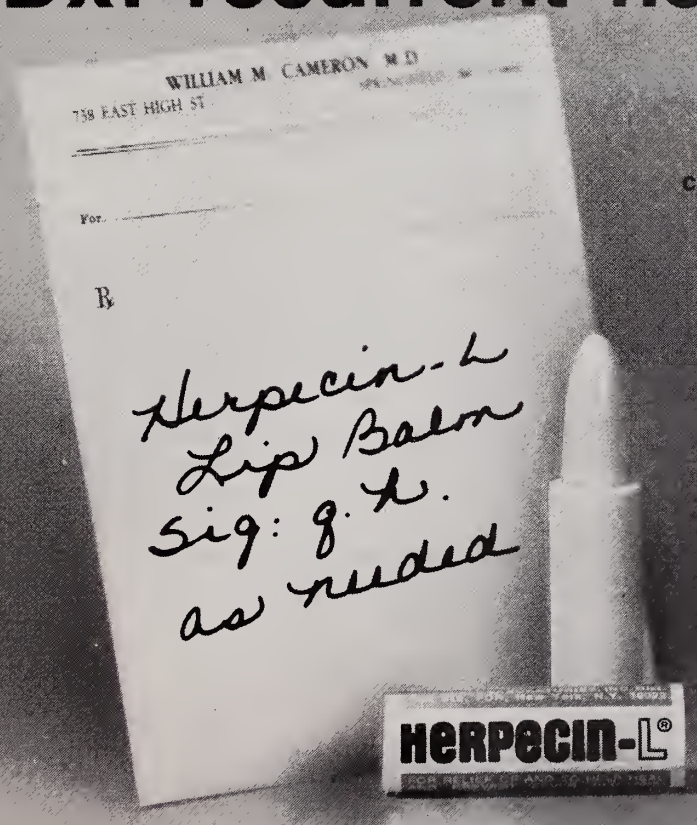
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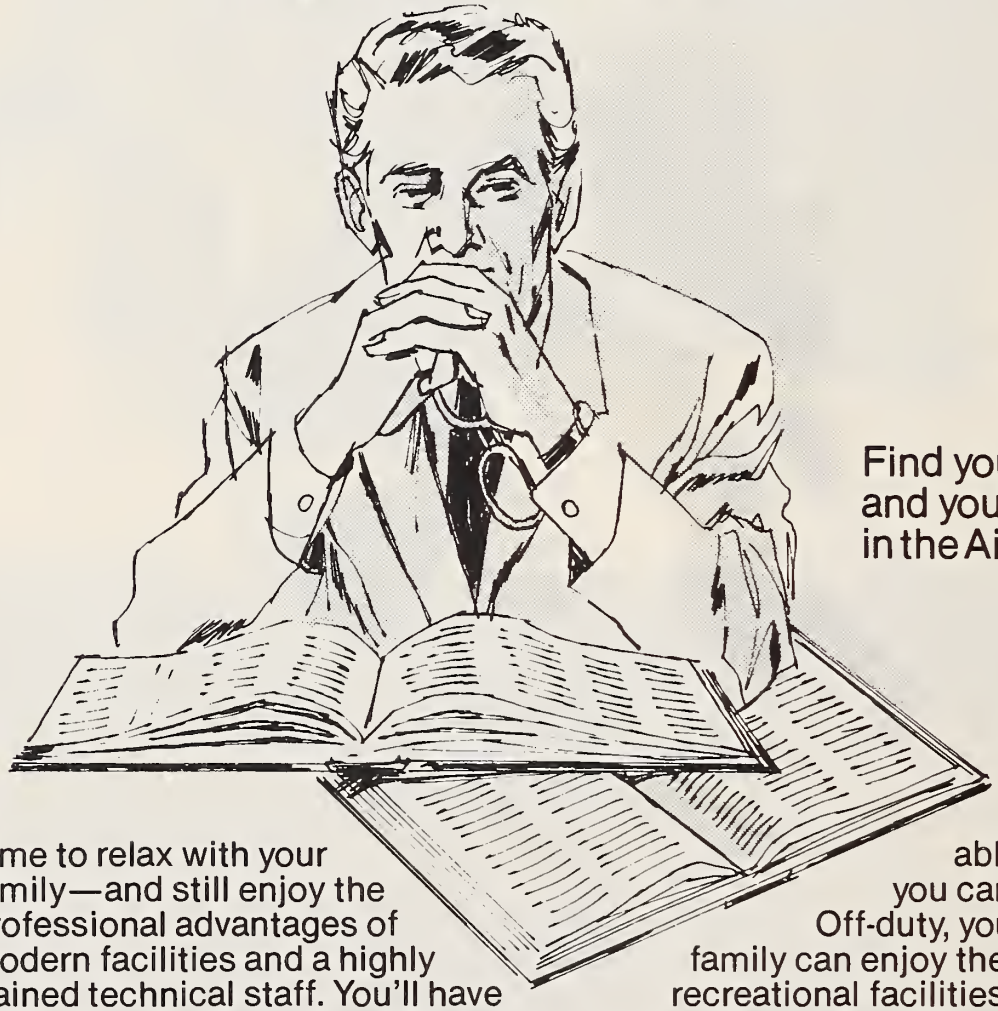
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AIR FORCE

Report of Reference Committee A

LaMar S. McGinnis, M.D., Chairman
Ray L. McKinney, M.D., Vice-Chairman

Reference Committee members listed on page 403.

President

Charles D. Hollis, Jr., M.D.

MAG is a very active organization. One almost has to serve as President for a year to realize how active it really is. The public has almost no grasp and the membership very little insight into the degree to which MAG involves itself in many matters related to health care delivery.

The role of President is also a rather active role in representing MAG, for instance, the President this year has participated in such things as:

— The Needs Assessment Discussion of the Board of Regents for its Educational Institutions;
— The Conference of the Southern Regional Education Board on the changing role of the nurse and patient care activities;
— The Inauguration Ceremonies of the new President of Morehouse Medical School;
— Presentations of various MAG activities at county medical society meetings;
— Participation in the forum at the AMA Leadership Conference on the progress in Georgia in organizing Hospital Medical Staff Officers;
— Discussions with the Council of Deans with the four medical schools regarding matters of mutual concern to MAG and the schools;
— Meeting with business leaders in planning and developing business/medicine coalitions;
— A conference with the new Governor requesting the appointment of an Advisory Commission on medical malpractice Tort Reform;
— Involvement with a work group at the AMA on development of a Health Policy Agenda for the American people; and, of course,
— Regular monthly meetings of the MAG Executive Committee and quarterly meetings of the Board of Directors.

MAG, in a general way, has had a successful year. Among the meaningful activities have been:

— Planning more intensive PR activities, particularly in the area of public education;
— The organization of the Hospital Medical Staff Officers statewide;
— The support and coordination of business/medicine coalitions around the states;
— The formation of the Council of Medical School Deans;
— Presentation of an informative Leadership Conference for MAG;
— Increased involvement of the *JMAG* in reporting MAG activities;
— More extensive inclusion of the Auxiliary in the MAG activities, particularly by addition of Auxiliary members to the committees;
— The bringing of MAG Mutual, our physician-owned liability insurance company, into full operation;
— The laying of the ground work for specialty society representation in the MAG House of Delegates;
— The continuation of the effective work of the Education Committee, particularly in the Accreditation of Continuing Medical Education Programs around the state;
— Another successful year for the Legislative Committee in attaining its goals at this year's session of the legislature;
— The presentation of medical malpractice Risk Management Seminars, a model for such seminars nationwide;
— Continued resounding success of the Impaired Physicians Committee, also a prototype for such physician rehabilitation programs throughout the country;
— Initial steps in preparing to bring MAG closer to [the Georgia] Medical Care Foundation again in operation of its Peer Review Activities;
— Work by the Third Party Relations Committee to advise and represent MAG's point of view on the new Medicaid and eventually Medicare regulations regarding reimbursement.

This is just a brief listing of some of many projects which the MAG through organization via its staff and committees are directing.

At this time it would seem appropriate to bring some up-to-date data on the progress of the MAG Mutual Insurance Company through its first ten months of operation. The assets are $6.2 million; investors 2,007; applications received are 1406; the number of insured physicians at this point is 1211; the total written premiums to date are 5.85 million; and the funds invested are $5.2 million. All of the operations of the company at the present time are encouraging.

The three matters listed below and designated A, B, and C address Reports and Resolutions presently pending in Reference Committee A. It is not my intention here to offer these as recommendations separate and apart form the recommendations contained in those Reports and Resolutions. Rather, it is simply intended as support for adoption of those items in such form and detail as the Reference Committee and the House feel is appropriate.

A. Establish and fund a full-time Public Relations Department to develop an intensive Education Program directed at both the public and the medical profession.

B. Approve the concept of a computer compilation of all MAG policies with an automatic "SUNSET" for those policies not renewed bi-annually or annually by the appropriate committees;

C. Provide a traveling indoctrination program, to go to all the major areas of the state each year for the purpose of informing young physicians and new members about MAG programs, how to deal with the various government agencies and changing government programs, and the importance of participating in the MAG Mutual Insurance Company.

Recommendations

1. Encourage the development, probably by the medical schools, of studies on cost effectiveness and appro-

priateness of care now being delivered, particularly to the aged and chronically ill.

2. Develop and propose alternatives to the individual primary care physicians of ways in which to deal with the large corporately owned primary health care centers.

House Actions

Adopted Recommendation 1.

Adopted Recommendation 2 as amended to read: "Develop and propose alternatives to the individual primary care physicians of ways in which to deal with the large corporately owned primary health care centers. These alternatives should be developed by the appropriate MAG committee as soon as possible."

1st Vice-President

V. W. McEver, Jr., M.D.

I have attended the meetings of the Board of Directors and the Executive Committee for the past two years. The Medical Association is confronted by many, many problems. Foremost among these is our present problem with the Federal Trade Commission, which is an additional unjustified burden placed on MAG by the government. On this particular problem our legal fees have amounted to over $165,000; further, there is the additional cost in staff time and travel, as well as extreme administrative inconvenience. To me, this is but one of the many intrusions into organized medicine that the government will be making in the future. It also indicates to me the great care which we have to take in order to state our position on medical principles and practice. If we are not very careful, we will be under a constant seige of suits and countersuits with each case establishing a new set of rules and regulations. When we take a position regarding our relations with paramedical groups, we must take every precaution concerning the legal aspects before we make this position a matter of public record.

The paramedical groups are demanding a greater position in the medical picture. They have found the easiest way to accomplish this is by changing the law. In the recent meeting of the [Georgia] legislature and the Congress, numerous bills were introduced which would have given great benefits to these groups and at the same time been detrimental to the health care of our citizens. One of the great benefits of belonging to the MAG and AMA is the organized resistance provided by our "representatives" to the legislature and the Congress.

We have seen an increase in membership resulting from our diligent efforts to bring in the residents and young physicians. I think we have made great strides in this area, and I would like to see the MAG make the same offer to the other physicians in Georgia who are not members of MAG.

The Medical Association at the present time has many activities and programs which we actively promote or sponsor. With the increase in activities and programs we have had increased costs, along with the usual increase due to inflation. We do not have enough income either from our dues or the usual alternate sources to pay for our budgeted expenses. MAG needs to take a close look at the programs and activities that we are now participating in and determine which ones should be continued.

Thank you for the opportunity to serve as your Vice-President these past two years.

Recommendations

In view of the above, I would recommend that:

1. We make a careful study of the legal complications that can arise from policy statements that the MAG makes from time to time;
2. We offer membership to all the *physicians* in the state of Georgia who are not members of MAG on the same basis that we have offered it to the residents; and
3. That we carefully review the programs and activities the MAG is now involved in and paying for, to determine whether or not they are necessary and whether or not they are feasible.

House Action

Adopted Recommendation 1.

Did not adopt Recommendation 2 and adopted two substitute recommendations:

1) "MAG and its component societies should work diligently to recruit for membership all eligible physicians," and
2) "The Membership Committee should conduct an investigation to determine the feasibility of amending MAG's Constitution and Bylaws so as to make Doctors of Osteopathy eligible for membership."

Adopted Recommendation 3 as amended to read: "That we carefully review the programs and activities that MAG is now involved in and paying for to determine whether or not they are necessary and whether or not they are feasible. Such review should be done annually through the existing committee structure of the association. Committees and other budget units and their staffs should justify their programs in their budgets and the Finance Committee should review critically all MAG activities and the funds requested for them."

Report of the Board of Directors

Jack A. Raines, M.D., Chairman

SUNSET Procedure on MAG Policies

In May, 1982, the Executive Committee of the Board of Directors adopted a report that proposed a program for the orderly, periodic, and systematic review of the existing MAG policy statements, many of which no longer serve the best interest of the profession and some of which are actually detrimental to the Association.

More specifically, the report adopted by Executive Committee offered a four-point plan to update policy positions advocated by MAG. They are:

1. Collect and assemble current policy positions that have been adopted by either Executive Committee, the Board of Directors, or the House of Delegates;
2. Submit each of these policies for review by the appropriate MAG committee to make a judgment as to whether or not any of these should be retained as is, expanded or contracted for clarification, or repealed;
3. Propose to the House of Delegates a "SUNSET" provision that would allow for the termination of outdated policy positions; and

4. Utilize the MAG computer for storage of our policy statements with the view that these will be retrieved on a regular, scheduled basis for review to determine if retention or "Sunset" is appropriate.

The Board of Directors subsequently adopted the report as presented by the Executive Committee and thus set in motion a review of all policy statements, public in nature, (as distinct to internal housekeeping statements) by one of the MAG committees.

The committees have made their recommendations back to the Board, and in a supplement to this report, the Board will list those policy positions that it feels should be repealed.

PURPOSE OF SUNSET: The MAG is faced with a system of health care delivery in Georgia that is rapidly changing. Our Executive Committee, Board of Directors, and House of Delegates have taken positions in recent years which remain "current policy" even though the need for such policy may have passed or the original situation requiring a policy statement may have changed considerably. The Board's plan to update and keep current the MAG *Quick Reference Guide* to Policies, Positions, and Statements, and to computerize our policies for easy access demand that a procedure be established for efficient and continuous review and for "Sunsetting" of policy positions when appropriate.

We think that review of MAG policies should be based on the following criteria:

1. Examination of the policy statement by physicians knowledgeable of the immediate circumstances surrounding the policy;
2. Approval of policy revision by physicians representative of MAG members;
3. Sufficient frequency of review to insure that MAG policies remain up to date.

Based on these criteria, the Board will assign all MAG committees the continuous responsibility of analyzing MAG policies in the context of ongoing developments; and when change in policy is advisable, of recommending changes to the Board of Directors for adoption. The Board will make annual reports on the revision in policy to the House of Delegates informing the House as to the reasons the change was necessary and explaining the purpose of the new language in the statement.

Recommendation

The Board of Directors shall submit to the House of Delegates annually a list of MAG policy statements, which in the opinion of the Board no longer serve the best interest of the Association. The presence of policy statements on the list shall be a clear indication that such statements are no longer the policy of the Association, effective the last day of the Annual Meeting at which they were presented, unless by action of the House they are removed from the list.

House Action

Adopted with commendation.

Access to Health Care Committee

M. Julian Duttera, Jr., M.D., Chairman

In the past year, the Committee on Access to Health Care has continued its two existing programs designed to recruit and retain privately practicing physicians in areas of Georgia suffering from a shortage of doctors. The Medical Fair and Pre-Practice Seminar — co-sponsored by MAG and seven other public and private agencies — has developed over the last several years into an established, effective mechanism to match resident physicians with small communities throughout the state. An examination of our Computer Placement Service has indicated that there is sufficient demand from physicians and communities to justify the service, but that improvements in the service are imperative if the service is to be of significant value to its users.

Medical Fair and Pre-Practice Seminar

The 1982 Fair, held in Atlanta on September 17-19, was by all accounts the most successful ever. Representatives of 44 Georgia communities and 99 residents attended, and the event achieved its two-fold purpose: to provide an opportunity for residents interested in practicing in small towns to meet with representatives of Georgia communities seeking new physicians; and to acquaint the residents and their spouses with the new problems they will face in making the transition from training to practice.

Of the 99 residents, 48 will be ready for practice this coming year. Of these, 19 are state scholarship recipients and are obligated to practice in cities of 15,000 or less in population. Two-thirds of all the physicians in attendance are in the specialties of family practice, internal medicine, obstetrics/gynecology, and pediatrics.

As in 1981, the 1982 Fair was a joint effort of the following organizations: The Medical Association of Georgia, the State Medical Education Board, the Georgia Academy of Family Physicians, the Georgia Hospital Association, the Joint Board of Family Practice, the Medical College of Georgia, the Southeastern Institute for Community Health, Inc., and the University of Georgia Cooperative Extension Service.

The same organizations are currently planning the 1983 Fair, scheduled for Augusta, October 14-16.

Georgia's communities continue to be enthusiastic about the Medical Fair, seeing it as an effective and inexpensive method of contacting a large number of residents already known to be interested in locating in small cities. Attendance by physicians remains high. A survey conducted immediately after the event drew highly favorable responses from communities, physicians, and spouses.

The conclusion of the committee's 1982 report on the Medical Fair still applies in 1983. With minimal funding, MAG has played a key leadership role in physician recruitment. The Medical Fair provides a unique opportunity for residents and community representatives to make the first contact in the recruitment process. The committee believes strongly that MAG should continue its involvement in this annual event.

Computer Placement Service

The committee's last annual report stated that concerns had arisen regarding the effectiveness of the Computer Placement Service. The committee pledged to investigate the usefulness of the service and to study means of improving it.

In its present form, the Computer Placement Service

consists of two lists which are updated twice a year. One list contains resumes of physicians interested in practicing in Georgia and the other contains information on communities, hospitals, group practices, etc., which are seeking to attract new physicians.

Since the AMA operates a nationwide placement service, a statewide service would in theory be superfluous. However, in fact the Georgia service is not duplicative, but complementary. A recent AMA listing showed 12 opportunities in Georgia. MAG lists 105. (In addition, over 40 small towns with hospitals were represented at the 1982 Medical Fair.) AMA listed 375 physicians compared to MAG's 268. Neither service can be expected to be perfectly accurate and up-to-date. Though the information overlaps, a user would benefit by subscribing to both services.

Requests for the opportunities list average about ten per week and for the physician lists approximately five per week.

The principal flaw in the Computer Placement Service is the infrequency of the updates. More frequent updates would provide obvious advantages to both physicians and communities.

Other areas where changes may be beneficial include: more active solicitation of entries among communities and residents; charging a modest fee to offset costs and to discourage "casual lookers"; switching from xeroxing to a professionally printed format.

The committee supports the retention of the Computer Placement Service, and of improving the service in 1983-84 by publishing more frequent updates.

Appalachian Regional Commission Physician Recruitment Program

An opportunity to expand the MAG's present efforts in recruitment has come in the form of a $53,000 physician recruitment grant from the Appalachian Regional Commission to the Georgia Department of Human Resources. DHR proposes to contract with MAG to carry out the work of the grant. The objectives of this program are:

(1) To survey the needs of 35 Appalachian Georgia counties for physicians;
(2) To develop a brochure giving information on communities which are potential location sites for new physicians;
(3) To recruit 15 doctors to serve in areas of need;
(4) To seek additional resources from private and public sources to expand the program to two years and to encompass the entire state.

The ARC funds will enable MAG to devote a full-time professional staff person to work in physician recruitment year-round. Contact will be established and maintained between communities and institutions seeking physicians on the one hand and medical schools and residency programs on the other. Thus, an active on-going effort will be made to match physicians to practice opportunities. The Medical Fair would then not be a single, annual event but a part of a comprehensive recruitment program. The Computer Placement Service would not be a mere list, the production of which is now an end in itself, but rather a tool in an overall recruitment effort.

The benefits of this 2-year program would accrue to the state as a whole by making medical care more accessible to tens of thousands of Georgians. Because of this benefit the committee is hopeful that the 2-year program can serve as a demonstration project and that on its completion the General Assembly will see the value of the effort and fund it in the future from general appropriations.

A very important by-product will also occur. MAG will have an opportunity to take positive legislative proposals to the General Assembly. This will counterbalance what is necessarily a largely negative legislative program which emphasizes working against harmful legislation rather than in favor of worthwhile proposals.

The Executive Committee approved this plan for physician recruitment at its March meeting and voted to recommend that the House of Delegates provide an exemption in this case from its 1976 policy directing MAG to attempt to disassociate itself from governmental contracts.

Recommendations

(1) That MAG continue to support the Medical Fair and Pre-Practice Seminar in 1983 in sponsorship and financial commitment.
(2) That MAG improve its Computer Placement Service by providing for monthly updates.
(3) That MAG make an exception to its 1976 policy on governmental grants and accept a contract with the Department of Human Resources to fund a full-time professional staff person to work in physician recruitment.

Fiscal Note

Funds for Recommendations 1 and 2 are contained in the committee's proposed 1983-1984 budget. Funds for Recommendation 3 would come exclusively from outside sources.

House Action

Adopted Recommendations 1 and 2.

Adopted Recommendation 3 as amended to read: "That MAG make an exception to its 1976 policy on governmental grants and accept a contract with the Department of Human Resources to fund a fulltime professional staff person to work in physician recruitment. Such a person should, if feasible, work under contractual arrangement with MAG rather than serve as an employee."

Impaired Physicians Committee

Edward J. Waits, M.D., Chairman

Your Impaired Physicians Committee met on several occasions during the last year. Accomplishments of the committee for the year include:

1. Changing the name of the committee from the Disabled Doctors Committee to the Impaired Physicians Committee in keeping with the national policy of the various treatment programs throughout the country and the AMA's revised nomenclature.

2. Institution of the Physicians' Advocate Program. This program is modeled after a similar one in Ontario. Canada, in which interested physicians throughout the state are invited to become advocates of the MAG Impaired Professional Program. These advocates will attend a seminar designed to educate each of them in the disease concept of alcoholism and to better understand the mechanism of early intervention, appropriate recommendations for treatment, and our MAG treatment program. These physicians will then be asked to advocate for

Georgia physicians returning to practice in their general locality. During the period of aftercare surveillance of 24 months and afterward, the advocate will serve with the recovering physician as a team for possible early intervention on future impaired professionals in the community.

3. Your committee chairman and designated members of the Physicians Consultant Committee continue to travel throughout the state as intervention teams for the identification and recommendation of appropriate management for impaired physicians.

4. Your committee chairman traveled to Durham, N.C., to the Center for Well-Being of Health Professionals for a 2-day seminar with Dr. John-Henry Pfifferling to discuss the implementation of the advocacy program and also to discuss the formation of an Impaired Professionals Committee for the Northside Hospital community. As a result of this seminar, Dr. Pfifferling was invited to Atlanta where he was involved in some lectures and workshop activity at Northside Hospital. It is hoped that a Physicians Wellness Committee at Northside Hospital will be established as a model for similar programs at various hospitals throughout the state. These programs can be hopefully meshed with the Physicians Advocates throughout the state thus forming a network of educated physicians in the field of alcohol and drug abuse and physician impairment in general. The problems of stress management and burn-out were also addressed by Dr. Pfifferling and will be included in the Physicians Wellness Committees as they are formed throughout the state.

5. The committee continues to support the Aftercare Committee of the Medical Association of Georgia which currently is monitoring the re-entry phase of 21 Georgia physicians who have returned to practice during the last year. There are currently 21 physicians being monitored under the 2-year aftercare contract. There are also 66 physicians who have finished the monitoring period but continue in the Caduceus Club.

Your committee would recommend the following:

Recommendation

That each county medical society be urged to select an interested member or members to serve as an advocate for impaired physicians in the local area and that hospital medical staffs and specialty societies in Georgia be asked likewise.

(Attachments — Available on request from the MAG.)

House Action

Adopted.

Membership Committee

William D. Logan, Jr., M.D., Chairman

Your Membership Committee has met on several occasions during the year and offers the following report:

Membership in the Association continues to grow and increase; however, it has not grown at the same rate as physicians entering Georgia and starting practice.

There are close to 8,000 physicians now practicing in Georgia and only 5,300 are members of the Medical Association of Georgia. This year MAG has become eligible for its sixth delegate to the American Medical Association; however, this is based on not only MAG/AMA members, but direct AMA members as well. There are physicians in Georgia who are not MAG members but do belong to AMA. MAG does get credit for them on its AMA delegate count.

At the end of 1982, there were 5,227 Georgia members of the AMA. Some 4,200 were MAG/AMA members with the rest being AMA direct members. It is interesting to note that 512 of these directs were students and 503 were residents. Your Committee has taken a long look at student and resident memberships and is formulating ways to bring in these members, especially the resident members. Present national figures show that 86.5% of all residents stay in the state in which they take their residencies. Georgia is above this national average. Ninety percent of residents stay in Georgia.

Other figures show that at least 65% of member residents become regular members while less than 25% of non-member residents join as regular members.

We feel that in order to get to these potential members, we must start at the student level, so we are formulating a program for them as well. We will offer later in the report recommendations which will aid this recruitment program.

In an effort to offer more tangible benefits to the membership, your committee has put together a membership benefits package which presently contains Hertz rental discounts, magazine subscription discounts, office supply discounts, and a patients' records filing systems discount buying program.

An all-member mailing has or will be out shortly telling of each program and how the member can benefit from each of these. MAG will also benefit financially from several of these.

The program is designed to offer more tangible benefits to the members by cost savings, help retain members, attract new members, and help keep dues down. We will be adding other benefits to this package from time to time.

Recommendations

1. That each county medical society and hospital medical staff put in place an active and ongoing recruitment program for membership in all levels of organized medicine.
2. That each county medical society having resident programs within its jurisdiction actively recruit and provide activities for resident members.
3. That each county medical society having a medical school within its jurisdiction actively work with the deans of those medical schools to better acquaint medical students with organized medicine, as well as involve medical students in appropriate activities of the county medical society.

House Action

Adopted all three Recommendations.

Physician-Lawyer Liaison Committee

L. L. James, M.D., Chairman

The committee has spent considerable time this year on possible revision of the *Principles Governing Physician-Attorney Relationships*. To date, we have been unable to mutually agree on any changes with the State Bar of Georgia. The cochairmen for the State Bar of Georgia are insistent on changes related to release of confidential information, but they have been unwilling to discuss their desired changes in a full committee meeting. The State Bar of Georgia does agree with us that the *Principles Governing Physician-Attorney Relationships*, adopted by

the Medical Association of Georgia and the State Bar of Georgia in 1969 and redistributed in 1973, are the principles in effect. Inasmuch as it has been 10 years since the *Principles* booklet was last distributed, we feel there is need for the guidance it provides.

Recommendation

We, therefore, recommend and plan a redistribution of the old *Principles Governing Physician-Attorney Relationships* if we are unable to agree on any changes before the State Bar of Georgia meeting in June.

House Action

Did not adopt.

Public Relations Committee

Charles W. McDowell, Jr., M.D., Chairman

It is the responsibility of the Public Relations Committee to provide advice, assistance, and coordination for all other committees on communications with the membership and the public. Your Public Relations Committee has met three times in 1982-83 to plan and carry out its objectives.

One of the major activities of the PR Committee this year has been the public opinion survey of Georgians on health care issues. We have published four articles in the MAG *Journal* (Jan., Feb., March, Apr.) on the survey results.

To our knowledge, the survey was the most comprehensive ever conducted in our state on health issues. The results contain some interesting and important findings, i.e.:

* The public is beginning to lose faith in physicians.
* A majority feel our fees are not reasonable.
* A majority believe we do not spend enough time with our patients.
* A majority believe the poor and/or elderly are not able to get needed medical care.
* Over 90% are satisfied with their latest visit to a doctor's office.
* The media probably plays a more central role in shaping public views on health care than personal experience.

The survey's findings are both comforting and shocking. On the one hand, the public's satisfaction with his physician is better than it has been in years, possibly ever. The public understands and appreciates the high quality of medical care being delivered today. And believe it or not, half of those Georgians polled say we do not spend enough on health care.

On the other hand, the public says they are losing faith in physicians, our fees are unreasonable, and we are not taking care of the truly needy.

Later in this report, we shall offer recommendations on what must be done to improve our image and "better tell our story." Unless we are prepared to stand by and ignore what the public is telling us, it is time to mount a major PR campaign.

Later in this report, we shall also address the problem of not having an MAG staff person to devote full-time to public relations. Although this House of Delegates approved such a recommendation back in 1979, it has yet to be implemented. Your PR Committee has concluded that an additional staff person be employed at MAG to work exclusively in a proposed PR Department. Such an individual should be professionally trained in public relations with PR experience. We also believe such staff should be given a liberal travel and entertainment budget. Your PR Committee has made such a budget request to the Finance Committee and hopefully that will be incorporated into MAG's 1983-84 budget to be voted on by this House of Delegates.

The PR Committee has also requested a budget for 1983-84 of $80,000. This request has gone to the Finance Committee. Your PR Committee figures this amounts to about the income of one office visit per MAG member. We believe that any physician concerned with the problems we have addressed is willing to spend that sum from the MAG budget. Incidentally, $80,000 is approximately 4½% of MAG's total budget for one year.

Your PR Committee is planning a statewide PR workshop scheduled for May 14 in Atlanta. The purpose of the workshop is to instruct MAG members, at the county society level, in how to design and implement an ongoing PR campaign at the local level. Invitations have been extended to county society presidents, presidents-elect, secretaries, and staff; district society officers; specialty society officers; committee chairmen; MAG Board members and officers; and any other MAG member who wishes to attend.

The Committee also is working on a slide presentation which can be taken to county medical societies to help in educating the membership in learning more about PR and what can be done at that level.

Your PR Chairman and staff have assisted the Medical Practice Committee in developing a brochure on health maintenance organizations (HMOs). MAG will also be purchasing space in the Atlanta papers to discuss the Association view on HMOs.

For the first time in MAG's history, MAG has purchased commercial TV air time to tell medicine's story. We actually put together a commercial along the lines of "Physicians Working Together For Your Better Health." It is the beginning of an image building program we hope to greatly expand this coming year. Heretofore, we have relied on public service announcements. The TV and radio stations, as this was "air time" they donate to public service, would run our messages rather infrequently and at odd hours.

We have continued to print the "I Want to Know What You Think" brochures. Over 100,000 have been ordered by physicians who make them available to their patients. It is one additional way the physician can evaluate how his patients regard the physician's practice. The brochures continue to be available at $2.00 per hundred.

We have continued to issue news releases when appropriate as well as letters to the editor. We had a meeting with the editorial board of *The Atlanta Journal* which we feel was beneficial. More of these type meetings should take place with every major paper.

Our public service announcements (PSAs) on the importance of donating one's organs so others may live more productive lives continue to be shown on some TV stations.

After all is said and done, it will be the physicians who decide how the public views them. Will our fees be reasonable? Will there be those who are not treated for lack of payment? Will we take the time necessary to not only make our patients well but communicate with them? Will the patient's welfare be more important than our monetary gain?

If we are doing our jobs as we should, the media cannot and will not lessen the respect physicians currently enjoy.

Recommendations

1. MAG establish, effective June 1, a PR Department within the MAG Headquarters offices. Public relations should be a top priority at the MAG.
2. An additional MAG staff person be employed to work *exclusively* in the area of public relations. Such a person shall have been professionally trained in PR with one to two years of experience in the field.
 Fiscal note: $20,000-$30,000 — The PR Committee has requested funding for this additional staffer of the Finance Committee. MAG's committees do not establish staff salaries. That will be left to the Executive Director and Executive Committee. The PR Committee has also asked that this staff person be given a liberal travel and entertainment expense account.
3. MAG mount a major PR campaign to improve the physician image and market the private practice of medicine as outlined in this report.

House Action

Adopted Recommendation 1.

Did not adopt Recommendation 2, and adopted a substitute to read: "A qualified individual be employed or assigned to work in the area of public relations, MAG's public relations being defined as that function designed to improve physicians' image and to promote the private practice of medicine to the lay public. This policy would not restrict the public relations committee from working in appropriate ways with physicians."

Adopted Recommendation 3 as amended to read: "MAG mount a major PR campaign to improve the physicians' image and to promote the private practice of medicine as outlined in this report."

Risk Management Committee

John Rhodes Haverty, M.D., Chairman

In 1982, up through February, 1983, the Risk Management Committee has been responsible for offering five additional seminars, including one each in Savannah, Bremen, Rome, and two in Atlanta. A total of 456 additional physicians have completed these seminars successfully. The seminars have netted, after expenses, over $15,000.

We have continued to receive plaudits from those who attend the seminars, as well as from outside our state. Virginia, Maryland, and New York all have indicated serious interest and have patterned seminars for their physicians based at least in part on the curriculum developed by the Medical Association of Georgia.

An evaluation of the first 3 years of the seminars has been completed, and has been submitted to the *Journal of the Medical Association of Georgia* for publication. Further evaluation, particularly as it relates to changes in behavior and actual reduction in claims or suits, must await another 2 years until sufficient actual data have been analyzed. Your committee and the St. Paul Insurance Companies continue to collaborate effectively and hope to present such an analysis as soon as possible.

MAG Mutual presently is collaborating with your committee also and is cosponsoring seminars as well.

Contact with the medical specialty societies and additional contacts with specific specialty representatives in Georgia continue to spark an interest in developing seminars that are individually specialty oriented. Work will continue on this aspect of future seminars during 1983.

To date, almost 1700 physicians have completed successfully the 18 seminars given so far. We have literally blanketed the state geographically and shall continue to cosponsor or sponsor seminars whenever interest is evident. Presently (February 1983) another seminar is planned for Savannah in March, and two more in Atlanta, the dates yet to be determined. Additionally, "spin-off workshops" for medical assistants have developed. Presently, there is also work being done in creating such Risk Management Seminars for all hospital employees. Preliminary work has been completed on this issue, and the development of a full curriculum is in process.

There have been some suggestions made that this committee be accorded the status of a "Special Committee," as opposed to its present "ad hoc" status. Since it is likely that such activity carried out by this committee will continue into the indefinite future, the suggestion seems to have merit, and I recommend such action be taken.

Recommendation

That the Risk Management Committee's status as an ad hoc committee be changed to a special committee.

House Action

Adopted.

Resolution 20

Access to Medical Care

DeKalb Medical Society, Inc.

RESOLVED, that the physicians of Georgia reaffirm their longstanding commitment to assure all citizens with access to quality medical care, regardless of their ability to pay.

House Action

Adopted the Resolution as amended to read: "That the physicians of Georgia reaffirm their longstanding commitment to assure all citizens access to quality medical care, regardless of their ability to pay."

The House added a clause to this resolution to read: "Resolved, that this resolution be forwarded to AMA through the MAG delegation for consideration for action."

Resolution 21

MAG Membership Recruitment Through Use of MAG Staff Outreach Program

Dougherty County Medical Society

RESOLVED, that the Medical Association of Georgia shall establish a team of MAG staff to travel each year to the larger component societies for the purpose of indoctrinating young physicians in the activities and benefits of the Medical Association of Georgia.

House Action

Did not adopt the Resolution and adopted a substitute to read: "That MAG establish a program to stimulate county medical societies to educate physicians regarding MAG's activities and the benefits of MAG membership and to

cooperate with the societies in this endeavor. Further, that MAG provide a specific team of MAG staff to travel to those areas to aid in this undertaking.''

Resolution 15

Conference on Training Future Physicians for the Competitive Marketplace

Charles D. Hollis, Jr., M.D.

RESOLVED, that the Medical Association of Georgia through its Education Committee, in cooperation with the state's four medical schools, should hold a conference on the subject of training future physicians for the competitive marketplace. Such a conference should present information on pertinent subjects, including the future medical needs of Georgia, and lead to the development of recommendations for action which may be submitted to the MAG Board of Directors. The Conference should be open to both private practitioners and medical school faculty and should be held preferably this fall.

House Action

Adopted the Resolution as amended to read: ''That the Medical Association of Georgia through its Education Committee, in cooperation with the State's four medical schools, should hold a conference on the subject of training future physicians for the competitive marketplace. Such a conference should present information on pertinent subjects, including the future medical needs of Georgia, and lead to the development of recommendations for action which may be submitted to the MAG Board of Directors. The Conference should be open to both private practitioners and medical school faculty. This conference should be held in conjunction with the MAG Leadership Conference scheduled for January, 1984.''

Cobb County Medical Society

Charles R. Underwood, M.D., Director

It is through no fault of those of us who settled in Marietta, and Cobb County, so many years ago in order to pursue a quieter life — to create an arm's length relationship with ''the city'' — looking for a bit of tranquility and hoping to pursue some of the pastoral life, that we find ourselves in 1983 entrapped in the county with the fastest growth rate and perhaps the most aggressive economy in the state. We look around and find ourselves with 313 CCMS-MAG members — 119 of those members of the AMA — and thus the third largest component society in the state organization. We did not plan it that way. And so we have decided, this in great part the wisdom of our new president, Richard Cohen, M.D., that the good justice Oliver Wendell Holmes knew of what he spoke back in the nineteenth century — ''As life is action and passion, it is required of a man that he share the passion and action of this time for fear of being judged not to have lived'' — and thus to grab hold of the action and get a piece of it.

We find our area — the Cobb County area — beset with a myriad of privately financed and independent health care centers of every description, manned by individuals unknown to the majority of our membership and providing a level of medical care outside our monitoring system. We live in the maelstrom of the fastest growing open panel HMO in the state and find many of our members actively participating not only in this plan but also in the several others available in the Atlanta area. Our patients, once thought solidly within the haven of our private offices, abandon long-standing ties and relationships for the seductive lure of medical care at a more predictable and hopefully lower cost. We see more clearly than ever that the status quo of the practice of medicine is fast becoming an anachronism in our world. The effort more clearly becomes one of preserving our long-standing ethical principles and quality of care — our doctor and patient relationship — in the face of the threatening changes imposed by the monetary reimbursement systems and the tightening medical care monitoring mechanism.

County and Secretary	Members 12/31/81		Members 12/31/82	
	MAG	AMA Dues Paying	MAG	AMA Dues Paying
Cobb Ronald Roper Marietta	273	174	286	167

Our plea, then, to the Annual Session of the Medical Association of Georgia is that this year, more than ever in the past, the issues before the Delegates be debated with a clear view of the impending massive changes already upon us and with a spirit of cooperating with the inevitable as well as with our friends in government and business as they try to reorganize our lives and our practices for the benefit of our patients — for the financial welfare of their own constituency — and hopefully with a view toward the preservation of a style of medical practice acceptable to most of us and attractive to those bright young men and women of the future who will need to replace us in years ahead.

Our Society continues an active one — a fresh breeze blows through as Richard Cohen, the new president, reshapes the organizational structure and forces involvement of a broader section of our membership. The Cobb County Symposium, with Noah Meadows, M.D., faithfully nourishing it along, continues a broadly-based interdisciplinary approach to the myriad of problems confronting not only medicine but the community as a whole. All of the county athletes receive a courtesy physical examination from the members of the CCMS with all of the games played being monitored by an attending physician. We have been proud of Barbara Thibodeaux from Cobb County occupying the chair of the president of the Auxiliary of the MAG this year and of the results of the several programs she has pursued. The local Auxiliary, with Mrs. Diane Roberts as President, also continues the pursuit of a variety of activities vital to the functioning of the local medical community.

And then one final word — to Charlie Hollis — the very sincere thanks of the members of the Cobb County Medical Society for conducting the office of this Association over the past year in such a manner that we can all be proud not only of him but of the organization which he represents and in a sense of ourselves also — and for the several innovative programs which he has nurtured along. For all of this we are forever indebted to you.

House Action

Adopted the Report as amended to read in the first paragraph: ''that Cobb County has 286 CCMS-MAG members [rather than 313], and thus is the fourth largest county medical society [not the third].''

Anxious patients improve in just a few days



And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

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Valium® (diazepam/Roche) Ⓥ Tablets
Valrelease™ (diazepam/Roche) Ⓥ slow-release Capsules
Injectable Valium® (diazepam/Roche) Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> *Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Report of Reference Committee B

Charles Harrison, M.D., Chairman
Rodney Browne, M.D., Vice-Chairman



Members of Reference Committee B — from L to R: Edmund Molnar, Roland Summers, Rodney Browne, and Neal Yeomans.

Charles Harrison, chairman, reported that all reports and resolutions referred to Reference Committee B were carefully considered. Reference Committee B met in Room 12 at the Columbus Convention & Trade Center, on Friday, April 22, 1983. Other members of Reference Committee B were Rodney Browne, vice-chairman; Dan Stephens, Marietta; Carl Hancock, Albany; Neil Yeomans, Waycross; Edmund Molnar, Columbus; and Roland Summers, Savannah.

Medical Practice Committee

W. Dan Jordan, M.D., Chairman

To simplify the report on the activities of this committee, we are listing subject matter and a brief description of the activities to date.

HMO Brochure: At the direction of the 1982 House of Delegates, the committee has spent a number of hours developing the content of an informational brochure on Health Maintenance Organizations. Copies of this brochure will be distributed to the membership as soon as they are printed.

MAG Policies: At the request of the Board of Directors, the committee reviewed and made suggestions for retention, revisions, or deletion on MAG policies relating to acupuncture, allied health personnel, biofeedback, hypnotism, medical consent (parental consent), optometry, radial keratotomy, second opinions, and freedom of choice. These recommendations will be approved, rejected, or revised by April, 1983, Board of Directors.

Do-Not-Resuscitate Guidelines: The committee is continuing its consideration of this subject.

Prescription Abuse of Amphetamines: The 1982 House of Delegates directed development of a statewide voluntary program to reduce abuse of prescription drugs, amphetamines in particular. The MAG cooperated with the MAA and other local county medical and pharmacy associations in a program which was implemented July 4, 1982, in the metropolitan Atlanta area.

During this time, the Composite State Board of Medical Examiners began consideration of addressing the problem by the rules and regulations process. It decided to request legislation to support its proposed actions. A bill was passed in the 1983 Georgia General Assembly giving the Board of Medical Examiners clearer rule-making authority. The Board of Medical Examiners is now developing regulations for implementation.

Workers' Compensation: On a request contained in a 1982 Resolution submitted to the 1982 House of Delegates by F. W. Dowda, M.D., relating to freedom of choice under the Georgia Workers' Compensation law, the Medical Practice Committee reviewed previous actions on this subject and heard explanations of the problem from both F. W. Dowda, M.D., and Tom Howell, M.D., of the MAG Committee on Occupational Health, which had addressed a similar Resolution in 1981.

The committee believes there is provision for more freedom of choice in the Workers' Compensation Selection of Physician Section than is generally understood. For this reason, it asked the MAG attorney to review the law and make suggestions as to how we can maximize the patient's freedom of choice consistent with the purpose of this law, and possibly establish provisions for employee advocacy in the determination process in lieu of, or in addition to, the appeal process provided by law. At the time of this report, the attorney's response is expected within a short time. A separate report or recommendation on this subject will be available at the 1983 House of Delegates.

Medical Staff Leadership Conference: A statewide conference on Medical Staff Issues was held on Friday, November 12, 1982, in conjunction with the first MAG Leadership Conference November 12-14 at Callaway Gardens. Topics of discussion on hospital medical staff relationships included credentialing and quality assurance; legal responsibilities and liabilities of the medical staff; administration and governing body; and changing trends in the medical care environment such as competition, contractual arrangements, changes in financing, etc. The content and presentations at this meeting received enthusiastic response.

JCAH: The committee reviewed material relating to actions of the AMA and the American College of Surgeons regarding the JCAH proposed changes of standards of "Medical Staff" to standards for an "Organized Staff."

Because of the widespread concern about this proposed change and the knowledge that this subject will be debated at length at the April 22-23 MAG House of Delegates, the Medical Practice Committee requested that the AMA have a representative at the appropriate Reference Committee to explain this change fully and specifically to respond to the following questions: What's happening — why is this change proposed? If due to litigation, what is the extent of liability? Who or what groups of providers or allied medical personnel will be included in the "Organized Staff?" What effect will this have on the individual physician and the medical staffs of local hospitals, e.g., how will it increase/decrease their liability in credentialing, management responsibilities, and in possible antitrust actions? How will it affect patient care?

Because of the large number of unanswered questions, the Medical Practice Committee chose not to recommend any specific position or action on this subject other than the recommendation that a knowledgeable AMA representative be at the upcoming MAG House of Delegates.

Diagnostic Related Grouping (DRG): The committee has continued to discuss the concept of prospective reimbursement outlined by federal law known as Diagnostic Related Grouping (DRG). Briefly, this is a prospective payment system on the basis of diagnosis rather than services. The Medicare affiliated hospitals will receive a lump sum prospectively based on their 1981 experience in each of 467 DRGs. The hospital then is expected to provide the care for that particular DRG with that sum of money. It is anticipated that changes or recalibration of the DRG prices would be made at least annually to allow for various cost changes. Hospitals would be rewarded for spending less than that sum of money for a DRG and penalized if they spend more than that particular sum of money. This particular prospective payment process is scheduled for implementation on October 1, 1983, though there is apparently some question as to whether this time schedule can be completed. In the interim, according to information supplied to the committee, hospitals are being reimbursed for their Medicare patients on a single sum per discharge formula. Without knowing the exact elements of the formula, it is difficult to provide exact information; however, the information received indicated that regardless of diagnosis or length of stay, the hospital would receive a specified amount of money per Medicare discharge. If this amount is less than the current average per Medicare discharge, the hospital must absorb the deficit.

The committee noted that this is another example of cost shifting mechanism that is being forced upon hospitals by participation in the Medicare/Medicaid type programs. The hospitals are frankly admitting that they must shift the cost of caring for the Fed-plan patients to the privately insured patients in order to balance their books. This, of course, results in the privately insured patients having to pay more for the medical care and certainly does very little to lower the overall cost of hospitalization. The committee feels that this is an obviously alarming trend and that it is extremely important that all of Georgia's physicians are aware of this manipulation of payment for hospitalization.

The committee also noted that in 1981 the House of Delegates adopted a recommendation from the Medical Practice Committee that the MAG oppose a Diagnosis Related Group reimbursement mechanism and to communicate this opposition to the appropriate agencies. The committee, therefore, recommends that MAG reaffirm its opposition to this concept of prospective payment reimbursement based on Diagnostic Related Groupings and that the MAG communicate this opposition on to the American Medical Association, the Georgia Hospital Association, and the Georgia Congressional delegation.

Recommendation

The committee recommends that MAG reaffirm its opposition to the concept of prospective payment/reimbursement based on Diagnosis Related Groupings and that the MAG communicate this opposition on to the American Medical Association, the Georgia Hospital Association, and the Georgia Congressional delegation.

House Action

Adopted the recommendation of the Medical Practice Committee as amended from the floor to include the content of the Reference Committee explanation for clarity. This makes MAG's position on prospective payment/reimbursement based on Diagnostic Related Grouping read: "The Medical Association of Georgia reaffirms its opposition to the concept of prospective payment/reimbursement based on Diagnostic Relating Grouping.

"The Association realizes that federal legislation has passed which requires the development of a prospective payment system for Medicare. From the testimony heard and the discussion at the 1983 MAG House of Delegates, it is the MAG's opinion that the nationwide implementation of this concept will create havoc. The Association is on record in opposition to this concept and the implementation of an insufficiently tested reimbursement mechanism."

This position will be communicated to those agencies listed in the Medical Practice Committee's recommendations.

Supplemental Report of the Medical Practice Committee

W. Dan Jordan, M.D., Chairman

Impact of Contractual Arrangements on the Physician/Patient Relationship

Over the past 5 years, the Medical Practice Committee has periodically reported on contractual relationships involving physicians in their practice environment. Since our last report on this topic (1979), other variations have surfaced that the committee felt should be reviewed. The committee was able to obtain information from the Hennepin County Medical Society, California Medical Association, Association of American Physicians and Surgeons, Metropolitan Atlanta Foundation for Medical Care, and from our legal counsel enabling the committee to make some observations about the most active of these variations known as Preferred Provider Organizations (PPOs).

A typical PPO is a group of fee-for-service providers who have a contractual agreement to provide health care services at a discount to a defined group of patients, who have choice of provider but have an economic incentive to utilize PPO member providers.

After a study of this information, the committee reached the conclusion that the following observations, essentially the same as those included in the 1979 committee report, should be reaffirmed and reported to the House of Delegates.

Advantages/Disadvantages of Contractual Practice Relationships

Advantages

1. Guaranteed payment
2. Simplification of forms
3. Possible practice protection by balancing the marketing advantages of prepaid plans and similar groups

Disadvantages

1. Discounted set fee structure (determined by the organization)
2. Necessity to perform various utilization review

programs (both concurrent and preadmission)
3. Risk-bearing
 a. Medical liability, possibility of involvement in malpractice allegations resulting from adherence to organizational guidelines
 b. Antitrust liability, possibility of legal attacks for restraint of competition
4. Possibly deprive physicians of their ability to make free decisions affecting individual patient care.

Recommendation

That the MAG House of Delegates approve the above advantages/disadvantages as reference points for evaluation of contractual practice relationships.

House Action

Adopted.

Third Party Relations Committee

A. A. McNeill, M.D., Chairman

The main focus of the committee during the past year continued to be the Medicaid Program, administered by the Department of Medical Assistance (DMA). The DMA has enacted several major changes which will be discussed individually below.

1. On November 1, 1982, the DMA completely revised their Physician Services Policy Manual. This manual was distributed to all enrolled physicians and is broken down by specialty so the manual becomes more easily understood. The Policy Manual sets out specifically the limitations and/or restrictions that apply to the various specialty areas.

2. The problem of filing a claim and never hearing from DMA seems to have been dramatically reduced. DMA reports that 98% of all physicians' claims are being processed (meaning either a check issued or claim rejected) within 30 days of receipt. An amazing 94.2% of all physician claims are being processed within 20 days after receipt by the DMA.

3. As part of DMA's attempt to reduce the costs of the Medicaid Program in Georgia, the Department has implemented a new reimbursement plan for certain procedures and services that are performed in the hospital setting, which are traditionally and commonly performed in a physician's office. Reimbursements for these type services are set at the lower of the physician's charge, or at 65% of DMA's maximum allowed payment.

4. At MAG's request and endorsement, the DMA removed the prior approval requirement for hysterectomy procedures. It was discovered that this requirement did not have a significant impact on the number of hysterectomies performed. The effective date of the removal of the prior approval requirement was January 1, 1983.

5. DMA enacted and implemented an Incentive Pay Program which provides monetary incentives to physicians who perform uncomplicated, simple surgical procedures in their offices as opposed to the hospital setting. The effective date for the Physician Incentive Program was February 1, 1983.

6. In an effort to reduce hospital admissions, DMA implemented a Mandatory Outpatient Services Program on certain minor/uncomplicated services. However, there are several circumstances which would allow these procedures to be done on an inpatient basis. These circumstances are: presence of medical conditions which will require postoperative observation by a nurse or skilled medical personnel; a simultaneous immediate procedure requiring hospitalization; or another surgical procedure which would routinely follow the initial procedure. If the medical necessity cannot be proven, the claim will automatically be rejected. The physician must then document the circumstances which required the performance of that procedure on an inpatient basis; effective date 2/1/83.

7. The Surveillance Utilization Review (SUR) system of the DMA has been in operation for some 15 months on a referral basis only. This system is one of the best utilization review units in the country. The SUR Unit identifies problems in billing and/or medical practice problems and alerts the Department so on-site audits can be conducted.

Medicare

Inpatient Radiology/Pathology Services: Under current law, the Medicare Part B (Physician Reimbursement) Program reimburses 100% of reasonable charges for radiology and pathology services rendered to hospital inpatients as long as specialists accept assignments. Under the new Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the reimbursement rate for these services will be 80% of reasonable charges. As a result, patients will be billed for the remaining 20% of reasonable charges that Medicare does not cover.

Surgical Assistants: Currently, Medicare reimburses physicians who assist in surgical procedures for their professional services. TEFRA prohibits reimbursement to physicians who provide surgical assistance in a hospital where qualified residents are available to perform this function, *except* under the following circumstances:

— Exceptional medical conditions exist;
— A team of physicians is needed to perform complex medical procedures;
— A patient has multiple medical conditions which require presence of another physician;
— Other exceptional circumstances as outlined by the Secretary of HHS.

Proposed Medicare Hospital Reimbursement System: TEFRA requires that the Secretary of HHS develop a prospective payment plan for hospitals and skilled nursing facilities to be presented to the Congress. It is clearly the intent of Congress to move from a retrospective system of reimbursement to a prospective system which establishes incentives for providers to control costs. Congress is apparently convinced that a predetermined reimbursement rate will encourage hospitals to focus on improving productivity and developing innovative health care delivery alternatives. In Georgia, the DMA-Medicaid already has a prospective payment system for those patients in hospitals.

Proposed Medicare Diagnostic Related Groups (DRGs): The HHS is considering proposing DRG as a scheme to tie into the prospective hospital reimbursement rate. The HHS has identified 467 DRGs, and the DRGs would determine the rate of the reimbursement to the hospital upon admission of a Medicare patient. The inherent problem with this concept is that the DRG scheme does not take into account certain factors such as geographic distribution of hospitals, that different hospitals serve different needs and patients, and the system does

not make special allowances for teaching hospitals who traditionally have had the more complex mix of patients.

The Third Party Relations Committee will keep the MAG membership informed as to all changes in Medicaid/Medicare or any other relevant changes in reimbursement mechanisms, whether they be public or private sector alterations.

SB-711: Payment of Medical Claims: As a result of the passage of SB-711 by the Georgia General Assembly in 1982, the Insurance Department of the State of Georgia now has the authority to levy fines on those health insurance companies who fail to pay a medical claim within 15 days after receipt of the claim. The insurance companies may request additional documentation which then begins another 15 day time period. This law authorizes the Insurance Commissioner to levy fines of up to $5,000 per violation for those companies who are not in compliance with this law.

Medicaid/Medicare Workshops for Physicians' Office Staffs: At the direction of the 1982 House of Delegates, the MAG co-sponsored several workshops for physicians' office staffs. These workshops were aimed at helping billing clerks, secretaries, nurses, medical assistants, and other personnel who deal with third party reimbursements for their physicians. Personnel from both the Department of Medical Assistance (Medicaid) and Prudential Insurance Company (Medicare Part B) taught the participants the correct way to complete Medicaid/Medicare forms, how to handle problem claims, collections, etc. These workshops have been enthusiastically received, and it is the desire of the committee to continue these worthwhile workshops.

Recommendations

1. That the MAG continue to cosponsor Medicaid/Medicare workshops for physicians' office staffs.
2. That the MAG encourage and cooperate with the DMA (Medicaid) to explore the possibilities of increasing the reimbursement rate for office visit charges.

House Action

Adopted Recommendation 1.

Adopted the Reference Committee recommendation to file Recommendation 2.

Resolution 1

JCAH Medical Staff Definition

Newton-Rockdale County Medical Society

RESOLVED, that the MAG urge the AMA through its delegation to reconsider its position and to retain the preexisting definition of "medical staff" in the JCAH Accreditation Manual for Hospitals.

House Action

Did not adopt.

Resolution 8

Revision of JCAH Medical Staff Standards

DeKalb Medical Society

RESOLVED, that the Medical Association of Georgia,



S. William Clark, Jr. (left), from Waycross, and E. Capers Palmer, Jr., from LaGrange, listen to a discussion of preferred provider organizations in Reference Committee B. H. Hilt Hammett, Jr., of LaGrange, Past President of MAG, is in the next-to-last row on the right.

through its duly-elected representatives to the American Medical Association oppose the proposed revisions in the JCAH standards and advise the AMA representatives to the JCAH to oppose the promulgation of the revised standards.

House Action

Did not adopt.

Resolution 9

JCAH Proposed Revisions to the *Accreditation Manual for Hospitals;* "Organized Medical Staff" versus "Organized Staff"

Harry Porter, Jr., M.D., Delegate
Cobb County Medical Society

RESOLVED, that the MAG House of Delegates instruct its delegates to the AMA House of Delegates meeting in June, 1983, to cast their votes and wield their influence in opposition to the deletion by the JCAH of the requirement for a medical staff in accredited hospitals, and to support the principles: (1) that it should be the responsibility of the organized medical staff and its individual physician members to comprehensively organize care for the needs of each specific patient; (2) that it should be the medical staff who recommends to the governing body of the hospital procedures which shall be employed in the delineation of privileges and in the conduct of utilization and peer-review activities; and (3) that the requirement for a medical staff structure, and assignment of these tasks to a medical staff organization, need not limit the delivery of services by a nonphysician clinician, provided those services are within the scope of his or her competence and license.

House Action

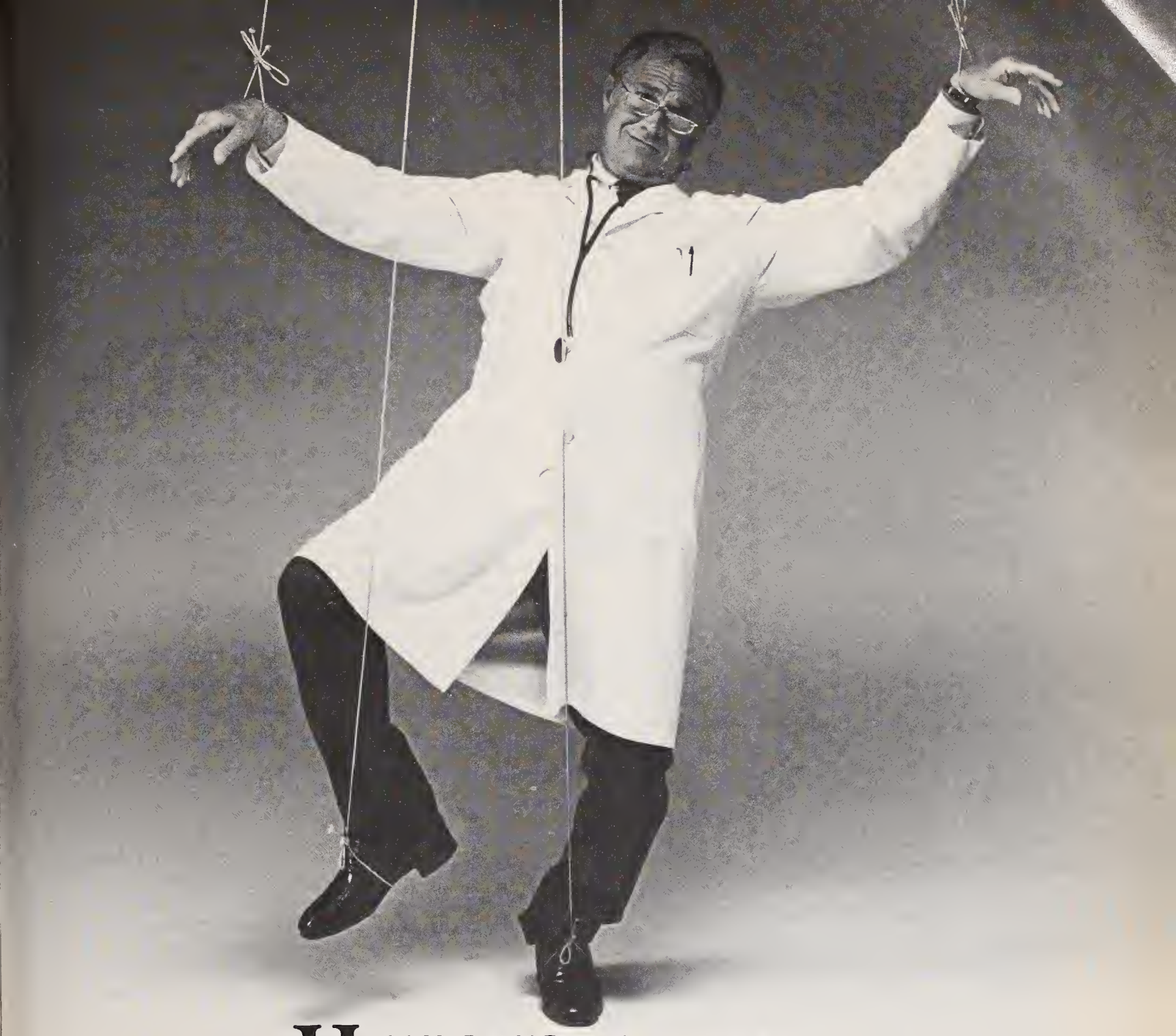
Did not adopt.

Resolution 13

JCAH Standards

F. William Dowda, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that the Medical Association of Georgia



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feels that the retention of the designation of medical staff and retention of the obligation of the medical staff to set standards for admission and treatment to and in a hospital is important and that if this can be accomplished in the new JCAH Standards, it should be.

House Action

Did not adopt.

Resolution 4

Free-standing Medical Clinics

Bibb County Medical Society

RESOLVED, that the Medical Association of Georgia fully investigate both the concept and application of free-standing medical clinics in the State of Georgia, and be it further

RESOLVED, that the information so gathered be fully passed on to our component society members and any appropriate action be considered at the state and national level.

House Action

Approved the referral of this Resolution to the MAG Board of Directors for disposition with instructions to consider all pending matters. It was understood that this would include recommendations made from the floor to consider substitution of the words "Emergency Clinics/ Centers" or "all clinics not completely owned by physicians," in lieu of the term "Medical Clinics" as included in the Resolution title and first paragraph.

Resolution 5

Business-Medicine Coalitions

Bibb County Medical Society

RESOLVED, that any representatives of state or county medical societies that sit on any business-medicine coalitions in existence or to be in existence be encouraged to avoid sacrificing quality of care issues solely in the name of cost cutting.

House Action

Adopted the resolution as amended to read: "The MAG reiterates its support of the concept of physician involvement in statewide and/or local medicine/business coalitions and urges those involved physicians to place strong emphasis on the quality of care to be provided in addition to cost containment."

Resolution 6

Preferred Provider Organizations

Bibb County Medical Society

RESOLVED, that the Medical Association of Georgia investigate fully the preferred provider organization concept, and be it further

RESOLVED, that this information be passed on to our component society members.

House Action

See House Action for Resolution 14.

Resolution 14

Preferred Provider Organizations

F. William Dowda, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that the Medical Association of Georgia go on record that it feels PPOs offer at best a questionable impact on the rising cost of medical care; that originally if a PPO is formed that all physicians should be "grandfathered" in, and that the county and state medical society should have the right of review of all evidence and make the final decision on whether or not one of its members will be removed from the PPO rolls.

House Action

Adopted the recommendation of the Reference Committee to refer Resolutions 6 and 14 to the MAG Board of Directors to direct and expedite further action relating to the issues involved in contractual practice arrangements and preferred provider organizations.

Resolution 10

Cost of Medical Care

F. William Dowda, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that the MAG endorse the idea of 10% across-the-board reduction in physician fees and lab charges and challenge business executives, businesses of all sorts, and labor unions to do the same for their wages and prices and also to cooperate with the development of appropriate deductibles and copayments with respect to insurance coverage to work to eliminate the abuse of uses that first-dollar coverage produces. One such idea would be for the Insurance Industry to develop a fee schedule which would serve as a floor and not a ceiling for physician charges. Such a schedule would of necessity require medical society participation and in the current climate would require permission of the FTC before such a collaborative effort could take place.

House Action

Adopted the Recommendation of the Reference Committee to refer this Resolution to the MAG Board of Directors for further consideration.

Special Reference Committee Recommendation

A synthesis of concerns expressed in testimony relating to the Medical Practice Committee report; its supplemental report; and Resolutions 6 and 14 (Preferred Provider Organizations).

House Action

Adopted the further recommendation of the Reference Committee to request that the MAG Board of Directors consider the total panorama of today's practice of medicine, including its quality; access and availability; modes of delivery; and cost, including reimbursement mechanisms, with the aim of developing positive action plans to resolve issues or provide Association members with information to assist them in making decisions relating to these issues.

Report of Reference Committee C

Philip Israel, M.D., Chairman
Robert Bradbury, M.D., Vice-Chairman

Reference Committee members listed on p. 404.

Health Planning Committee

Thomas J. Anderson, Jr., M.D., Chairman

Two main areas of health planning in the state deal with (1) the Certificate of Need process and (2) the State Health Planning and Development Agency's (SHPDA) "State Health Plan." The committee submits the following report:

1. *Certificate of Need (CON):* In the 1983 Georgia General Assembly, new CON legislation was presented and passed both houses. Several significant changes were enacted which affect health institutions, but still do not affect individual practicing physicians. Briefly, these changes are:

a. *Increasing Thresholds:* The minimum dollar thresholds for CON review were raised from $150,000 to $400,000 for capital expenditures for major medical equipment and from $150,000 to $600,000 for capital expenditures for the construction or installation of a building project (i.e., a new hospital or a new wing for a hospital).

b. *Projects Excluded from CON Review:* Several projects or capital expenditures that are excluded from the review process are: the replacement of existing equipment; acquisition of existing health care facilities; institutional or business infirmaries operated for the benefit of students or employees; safety, occupational, fire, building, environmental, or life safety standards necessary for compliance with licensing requirements; marginal changes in hospital bed capacity; and, of course, physician and dentist offices.

c. *Streamlining CON Review Process:* All references to Health Systems Agencies (HSAs) were deleted, since their decline in funding and termination seem imminent. County commissions and other local groups interested in CON matters can hold public hearings, but all CON review determinations will be made on a statewide basis by the SHPDA. The old State Health Coordinating Council has been replaced by the State Health Policy Council, whose members shall be appointed by the Governor. The CON review provides for an Independent Appeals Review Board with separate legal counsel to assure fair appeal hearings. This legislation also calls for the creation of a Health Planning Oversight Committee of the Senate and the House of Representatives to review the SHPDA and Health Policy Council actions, as well as approve the rules and regulations of each body.

2. *SHPDA's State Health Plans:* During the past year, the committee spent considerable time and effort reviewing, revising, and making comments to the SHPDA regarding different sections of SHPDA's State Health Plan. The committee asked MAG members, specialists in various fields of expertise, and organizations to help the MAG committee in its recommendations to SHPDA regarding the State Health Plan. The areas reviewed this year by your committee were: cancer, family planning, prenatal care, alternatives to conventional maternity care, mental health, occupational health, specialized cardiac services, primary health care, health education, long-term care, hospice, short-stay hospitals, CT scanning services, cost containment, and renal disease services.

Recommendation

That the Health Planning Committee continue to observe and act as watchdog for the MAG the activities of all agencies dealing with health planning.

Fiscal Note

$500 for the purchase of materials and staff travel.

House Action

Adopted with commendation the Committee's recommendation.

Committee on Medicine and Human Values

William Weston, III, M.D., Chairman

The Committee has met twice during the year. We have agreed that a primary goal of our work shall be to help increase the number of hospices in Georgia, to continue to inform physicians of hospice care, and to monitor legislation concerning hospice.

Hospice is the care of dying patients, for whom therapeutic treatment is no longer appropriate. Such care is directed toward control of pain for the patient and toward counseling for family members. It is administered by an interdisciplinary team which is medically directed and nurse coordinated, involving physicians, nurses, ministers, psychologists, social workers, and trained volunteer visitors. Their work is applicable to both in-patient and home care.

Federal legislation on hospice was enacted in November, 1982, providing for the extension of Medicare benefits for a test period of 3 years, starting November 1, 1983, for persons who are terminally ill. The legislation provides recognition for hospices as distinct providers of care, specifies the hospice services eligible for reimbursement, and sets a total benefit period of 210 days. It also affirms that the patient and family are considered as the unit of care (thus allowing counseling and family services), and stipulates that hospice care programs are to remain primarily home based, though a patient need not be home bound to receive services.

State legislation on hospice was introduced into the Georgia General Assembly in January, 1983. The purpose of this legislation is to set an appropriate definition for hospices, which are expected to grow in number as Medicare benefits become available. The Georgia Hospice Organization worked with Representative Bobby Phillips of Savannah in drafting Substitute House Bill 10 for this purpose. The committee formally endorsed this bill, communicated its support to the MAG legislative staff, and conveyed its support directly to legislators.

As of March 1, Substitute H.B. 10 has passed both houses of the General Assembly and is on its way to being signed by the Governor.

Informing physicians about hospice remains a goal of the committee, and we note that an article on "Hospice Care — An Alternative," by Dr. Paul T. Werner of Macon was published by the *Journal of the Medical Association of Georgia* in its issue of October, 1982.

Physicians' attitudes toward the terminally ill are important factors in patient care, and the committee believes that physicians must understand the ethical and philosophical aspects of death in order to be effective practitioners. For this reason, the committee endorsed the idea that medical school curricula should include instruction on these various aspects of death, and we recommend that the MAG officially endorse this position as well. Thus, at the request of the committee on February 13, 1983, the MAG Executive Committee directed that the deans of the medical schools in Georgia be encouraged to include in their curricula the appropriate instruction on the multiple aspects of death and their relation to the care of the critically and terminally ill.

As Chairman, I wish to thank the members of this committee for their support and involvement: Mary Ann T. Hagler, Augusta; Gary N. Harrison, Statesboro; Fredric K. Kratina, LaGrange; Martha J. McAnulty, Atlanta; Walker C. McGraw, Norcross; Hans J. Peters, Columbus; Richard B. Stewart, Decatur; Caroline J. Williams, Savannah; and Mrs. W. Jack Smith, St. Simons Island.

Recommendation

That the MAG, through its Committee on Medicine and Human Values and its Committee on Legislation, continue to monitor legislation and regulations affecting hospice care in Georgia, with the aim of promoting the growth of appropriate hospices in the state.

House Action

Adopted the following substitute recommendation of the Reference Committee: "That the MAG, through its Committee on Medicine and Human Values and its Committee on Legislation, continue to monitor legislation and regulations affecting hospice care in Georgia."

Resolution 3

Informed Consent Legislation

Hall County Medical Society

RESOLVED, that the Medical Association of Georgia participate in the development of informed consent legislation which meets the needs of patients and physicians.

House Action

Adopted the following substitute recommendation of the Reference Committee: "That the MAG participate in the development of informed consent legislation, if necessary, which meets the needs of patients and physicians."

Resolution 7

Informed Consent Legislation

DeKalb Medical Society

RESOLVED, that the House of Delegates direct the MAG Legislative Committee to develop alternative legislation to informed consent that would accomplish the primary goals of the legislation on informed consent now pending in a Georgia Legislative Study Committee but eliminate the onerous provisions.

House Action

Did not adopt.

Resolution 12

Freedom of Choice — Workmen's Compensation

F. William Dowda, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that MAG seek legislative repeal of this provision of Workmen's Compensation laws and allow freedom of choice of physicians under this law.

House Action

Adopted

Resolution 16

House Bill 528

Joe Almand, M.D., Troup County
Medical Society

RESOLVED, that the House of Delegates of the Medical Association of Georgia affirm its position that quality medical care should be ascertained for all nursing home patients, and be it further

RESOLVED, that the Georgia Medical Care Foundation is best qualified to do true peer review for quality of health care, and be it further

RESOLVED, that a copy of this Resolution be forwarded to the Governor and all appropriate legislators.

House Action

Adopted a substitute from the floor that read: "That the House of Delegates of the MAG affirm its position that quality medical care should be ascertained for all nursing home patients and that the Georgia Medical Care Foundation is best qualified to do peer review for quality health care for nursing home patients, and that a copy of this resolution be forwarded to the Governor, all appropriate legislators, and the Board of Human Resources.

Resolution 17

Usual, Customary, and Reasonable Fees

W. Daniel Jordan, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that MAG rescinds any previous approval of the concept of UCR fees and urges that physicians adopt the practice of establishing fees by negotiation directly with the patient.

House Action

Referred this resolution to the MAG Board of Directors with instructions to report back to the 1984 House of Delegates with its recommendation.

Resolution 18

Definition of Private Practice of Medicine

W. Daniel Jordan, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that MAG House of Delegates defines "private practice of medicine" as direct billing, fee-for-service medical care where the fee is determined by negotiation between the patient and the physician.

House Action

Referred this resolution to the MAG Board of Directors for appropriate action.

Report of the Board of Directors — D

Medicaid

Jack A. Raines, M.D.,
Chairman of the Board

Recommendation

The Board of Directors recommends that the Medical Association of Georgia cooperate with the Department of Medical Assistance and encourage the DMA to adjust the fees paid for all services to make these fees more in line with current charges.

House Action

Adopted.

Report of the Board of Directors — C

Medicaid

Jack A. Raines, M.D.,
Chairman of the Board

Recommendation

The Board of Directors recommends that the Medical Association of Georgia communicate to the Department of Medical Assistance that the problem of reduced fees is compounded by the administrative burden that is placed upon the physician and that the combination of these problems will inevitably result in a reduction of physician participation in this program to the detriment of the patients served by the program.

House Action

Adopted.

RESOLUTION 25

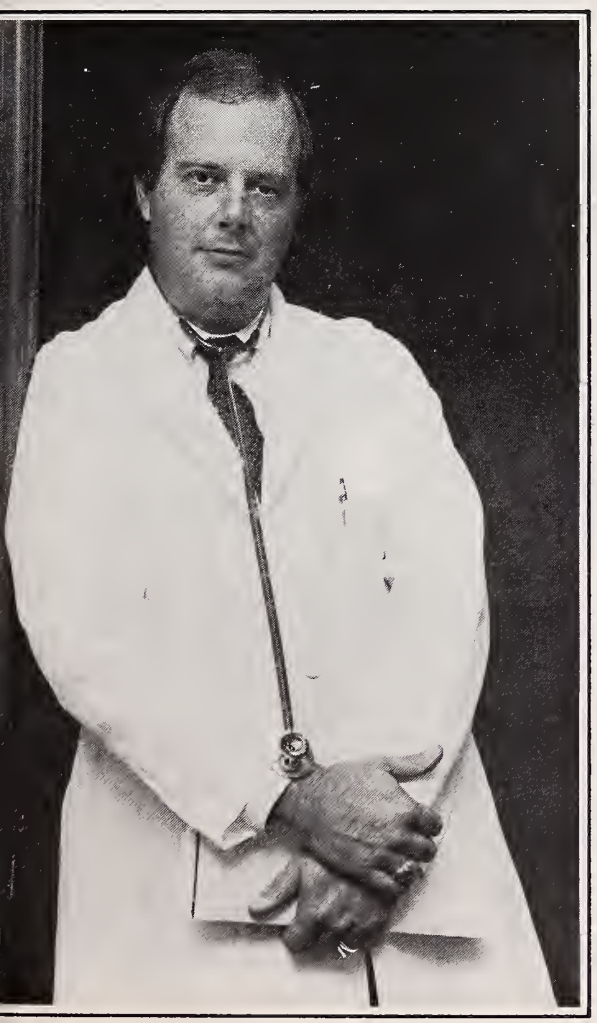
Slotted Seat for Resident and Student on the AMA Board of Trustees

F. William Dowda, M.D., AMA Delegate

RESOLVED, that MAG endorse the creation of a voting seat for a resident and a non-voting seat for a medical student on the AMA Board of Trustees.

House Action

Adopted.



"I told him to get help for his drinking. He told me to go to hell."

Too often, the hardest part of treating alcoholism is persuading patients to seek help. Many patients refuse because they think their problem is "just a little one."

Fenwick Hall has the staff, the facilities and the compassion to treat any stage of alcohol or drug addiction. Our 4 to 6 week specialized program incorporates medical detoxification and counseling with a unique Family Program, comprehensive After Care and the tenets of AA to enhance self-growth and recovery without sacrificing dignity.

If one of your patients has a problem with alcohol or drugs, you need to know about Fenwick Hall.



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Famous Pairs.



The Columbia space shuttle was a triumph of teamwork. And along with Young and Crippen went Anusol-HC Cream to treat prior anorectal conditions aggravated by "G-Force" stresses of exiting and reentering the earth's atmosphere.

Anusol-HC® & Tucks®

...another well-known pair that work so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs.





Anusol-HC®
Suppositories/Cream with Hydrocortisone Acetate

*The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders***

- ☐ *Antiinflammatory, to relieve itch, pain, and edema.*
- ☐ *Astringent, to protect against further tissue damage.*
- ☐ *Emollient, for easier bowel movements.*

Please see opposite page for brief summary of prescribing information.

**Meeting of Am Soc Colon/Rectal Surgeons, May 1980*
***Data on file, Marketing Research Dept, Parke-Davis*

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PD-85-JA-1336-P-1 (11-82)

And, when pain is a special problem, Anusol® Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS® ***Pre-Moistened Hemorrhoidal/Vaginal Pads***

*The #1 hemorrhoidal** pad for added external relief and gentle cleansing.*

- ☐ *Soothes, cools, comforts, and cleanses irritated anorectal areas.*

Once pain and inflammation subside, for dual action recommend regular ANUSOL® and TUCKS.®

PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950

TUCKS®
Pre-Moistened Hemorrhoidal/Vaginal Pads

Hemorrhoids and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0 mg; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS"

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

Candidates for nutritional therapy...

25,500,000 geriatric patients.

The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.*



Berocca Plus. A balanced formula for prophylactic or therapeutic nutritional supplementation. Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

...candidates for

Rx ONLY **Berocca® Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

*Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease,* edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 781.

Please see summary of product information on reverse page.

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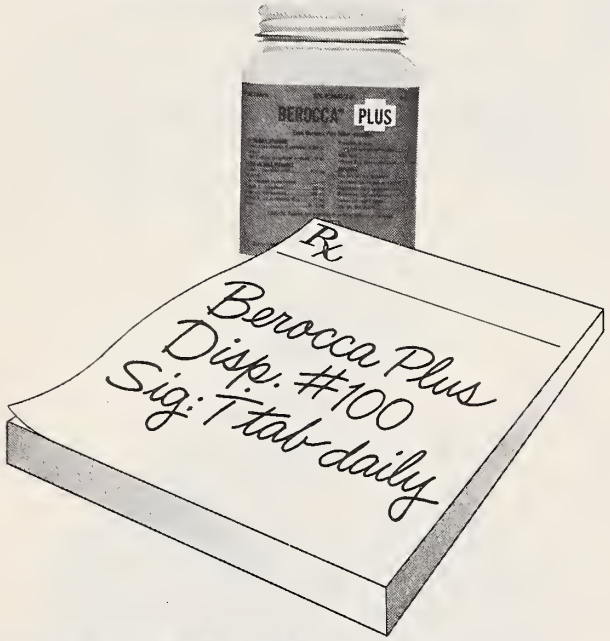
ROCHE®

Optimize nutritional support with

Rx ONLY

Berocca® Plus TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION



Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. **3.** Spicehandler J *et al: Rev Infect Dis 4*:562-565, Mar-Apr 1982. **4.** Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. **5.** Ronald AR: *Clin Ther 3*:176-189, Mar 1980. **6.** Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother 6*:231-239, 1980. **7.** Gower PE, Tasker PRW: *Br Med J 1*:684-686, Mar 20, 1976. **8.** Cosgrove MD, Morrow JW: *J Urol 111*:670-672, May 1974. **9.** Iravani A *et al: Antimicrob Agents Chemother 19*:598-604, Apr 1981. **10.** Schaeffer AJ, Flynn S, Jones J: *J Urol 125*:825-827, Jun 1981. **11.** Rous SN: *J Urol 125*:228-229, Feb 1981. **12.** BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category *C*. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: *Not recommended for infants less than two months of age.*

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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In vitro studies demonstrate

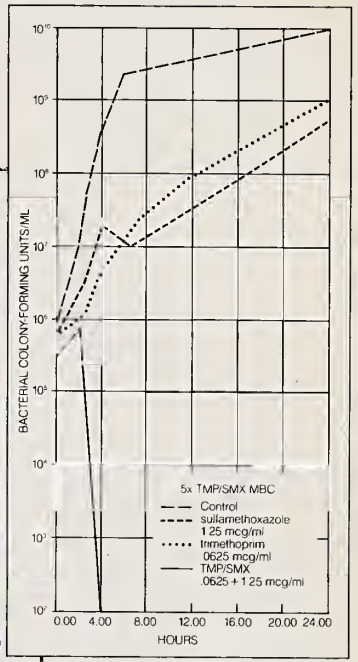
Bactericidal activity with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus sp.*	*Enterobacter sp.*	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofur-antoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI* *



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro*.[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

Motrin®
ibuprofen, Upjohn
600 mg Tablets



More convenient for your patients

Upjohn

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J-9043-4 July 1981

Report of Reference Committee D

Alexander H. S. Weaver, M.D., Chairman
Louis Felder, M.D., Vice-Chairman

During its meeting of April 22, Reference Committee D gave careful consideration to its referred reports and resolutions. Members of the Committee were: Alexander H. S. Weaver, Macon, Chairman; Louis H. Felder, Atlanta, Vice-Chairman; Walter Voyles, Waynesboro; Roy W. Vandiver, Decatur; Dan H. Willoughby, Savannah; William H. Wolff, Columbus; Thurman Clemons, Statesboro; and Edward H. Smith, Jr., Augusta.

Committee on Physician's Assistants

Richard W. Cohen, M.D., Chairman

This committee has met three times in the last year and has organized other meetings with representatives of the Composite State Board of Medical Examiners and the Georgia Association of Physician's Assistants.

For this year we agreed to work on several projects:

1) establishing an appropriate examination as a requirement for the certification of PAs in Georgia;
2) investigating the functioning of PAs in Georgia hospitals;
3) assuring adequate linkage of physician and PA.

Certifying Examination for Physician's Assistants

As directed by the Board of Directors and House of Delegates in 1981, this committee has been at work to get the Composite State Board of Medical Examiners to add as a requirement for PA certification the passage of an approved certifying examination. Currently, the only exam in use by over 40 states is that of the National Commission on Certification of Physician's Assistants (NCCPA).

I met with Dr. Jim Anthony, Medical Director of the Composite State Board, on August 4, 1982, and laid plans for a "summit" meeting to discuss adding the NCCPA exam as a requirement for PA certification in Georgia.

On September 29, representatives of the Composite Board and its PA advisory committee, the National Commission on Certificate of Physician's Assistants, plus the Georgia Association of PAs met with Dr. Bill Rawls and myself to discuss the exam. We agreed that the main problem stems from the Emory anesthesia PA program — its graduates are not prepared to pass an exam on general PA skills. We thought that the Composite Board should seek legislative authority to institute an appropriate exam, including one eventually for anesthesia PAs.

Our committee therefore determined that the MAG, through its Legislative Committee, should work with the Composite State Board in approaching the General Assembly and seeking legislative authority for the Composite Board to administer an appropriate examination. The MAG Executive Committee approved this plan on November 12.

At a second "Summit meeting" on November 22, however, we learned of difficulties in getting the test established. Thus, we were unsuccessful in our efforts to obtain testing authority for the Composite Board during this legislative session. During the coming year, we plan to continue our efforts and approach the General Assembly in 1984. For this reason, we have made Recommendation #1.

PA Use in Hospitals

With the help of the GHA, last fall we mailed a questionnaire to all Georgia hospitals requesting information on the functioning of PAs within the hospital. We found that more than half of the responding hospitals do not have PAs functioning within their doors and that most of these were smaller hospitals (under 100 beds):

Summary: Are PAs Used in Your Hospital?
(Total Hospitals Responding: 69)

No. of Beds	*Yes*	*No*
1-99	6	24
100-149	2	3
150-199	6	4
200-249	4	1
250-299	3	2
300-399	3	1
400-499	2	0
500+	7	1
	33	36

We also found that it is not clear whether a problem exists regarding hospital use of PAs. Bylaws provisions submitted by responding hospitals, for instance, are inconclusive as to whether sufficient monitoring of PAs is taking place. The committee intends to investigate this issue in cooperation with the Georgia Hospital Association.

Assuring Adequate Linkage of Physician and Physician's Assistants

The adequate supervision of PAs remains an issue of concern to the committee. We have found that the definition of supervision as adopted by the House of Delegates in 1978 is in need of amendment. That definition, currently in effect, is as follows:

> "The MAG defines direct personal supervision of physician extenders as being in the physical presence of the responsible physician or his covering physician designee on a daily basis, and that all decisions regarding diagnosis and treatment must be after direct personal or phone contact with said responsible physician or his covering physician designee."

The committee has discussed this statement and proposes that it be revised to read as follows (see Recommendation #2):

> "The MAG defines supervision of physician extenders as being in contact with the responsible physician or his covering physician designee on a daily basis, and that all decisions regarding diagnosis and treatment must be approved by said responsible physician or his covering physician designee."

As chairman, I wish to thank the members of this committee for their support and involvement: Louis G. Cacchioli, Hartwell; Paul E. Fitzpatrick, Morrow; Julius T. Johnson, Augusta; T. M. Martin, Carrollton; William W. Rawls, Decatur; Thomas L. Tidmore, Jr., Atlanta; John P. Wilson, Atlanta; and Mrs. Myron Katz, Atlanta.

Recommendations

1. The MAG, through its Committee on Legislation and Committee on Physician's Assistants, should cooperate with the Composite State Board in seeking legislative authority for the Composite State Board of Medical Examiners to administer an appropriate examination for the certification of physician's assistants in Georgia.
2. That the MAG adopts the following definition of supervision of physician's assistants:

 "The MAG defines supervision of physician extenders as being in contact with the responsible physician or his covering physician designee on a daily basis, and that all decisions regarding diagnosis and treatment must be approved by said responsible physician or his covering physician designee."

House Action

Adopted Recommendation 1.
Did not adopt Recommendation 2.

Ad Hoc Committee on Specialty Society Representation

W. W. Moore, Jr., M.D., Chairman

At the 1982 MAG House of Delegates, two resolutions from the Medical Association of Atlanta called upon the MAG to consider the issue of specialty society representation in the House. The House referred the issue to the Board of Directors, which was directed "to send [it] to the appropriate committee for study and report its findings back to the Board of Directors. The Board of Directors will then report back to the House."

Accordingly, last June 5, the Board created this *Ad Hoc* Committee to study the feasibility of specialty society representation in the House. On August 25, we met with the MAG Interspecialty Council; since then we have polled the specialty societies themselves and have gathered much information.

We have prepared the bulk of our research statistics in a supplemental packet for this Handbook. Here we wish to present a summary of our findings:

1. We think it important to point out that under the current format of the MAG House, a delegate elected by a county medical society is not obligated to represent the views of his specialty society. Thus, while our 1982 House had as delegates ten pediatricians, these physicians were elected to represent the views of their county societies, not necessarily those of the Georgia Chapter, American Academy of Pediatrics.

2. Even in these terms, our current House format allows for inequitability in "representation" of specialties. Some specialties such as anesthesiologists or ob/gyn have been recently underrepresented, while others (such as family physicians/general practitioners, internists, and general surgeons) have been overrepresented. For the last 3 years, the MAG House has had no delegate who is an allergist, emergency physician, nuclear medicine physician, or rheumatologist, even though each of these Georgia societies is recognized by the MAG Interspecialty Council.

3. The need for good communication between the Medical Association of Georgia and state specialty societies has been recognized by the MAG for over a decade. The MAG Interspecialty Council was created in 1971 to enhance this liaison.

4. The need for direct access for specialty societies to the House of Delegates was recognized by the MAG House in 1973 when it approved the Interspecialty Council's recommendation that a delegate and alternate be added for each society recognized by the Council. (The following year, however, the House reversed its position.)

5. The Interspecialty Council has formal guidelines for recognition. To date, 25 societies are members; five other societies have applied but have not been accepted. Furthermore, the Interspecialty Council has recently reviewed its guidelines for recognizing state specialty societies and is proposing more extensive guidelines to the Board of Directors.

6. With only one or two exceptions, the state specialty societies strongly favor direct representation in the House. Most support the idea of one delegate and alternate per society, but a few think representation should be either proportional or through representatives of the Interspecialty Council.

7. Almost half of all state medical associations have provided for direct representation of specialty societies in their Houses of Delegates. Many of these associations have done so in the last 2 or 3 years, indicating the growing strength of specialty societies in organized medicine.

8. The AMA has concluded that the concept of specialty society representation has worked well despite ongoing concern over the size of its House of Delegates. The benefits of society representation have been enumerated in a number of AMA reports:

 a. Society representation allows all significant organizations to work under the AMA umbrella instead of forming their own "umbrella" outside of the AMA.

 b. Specialty delegates attend House meetings with a clear identity, an understanding of whom they represent, and with an organizational decision-making process behind them.

 c. The specialty societies have sponsored a variety of resolutions and have participated fully and responsibly in all AMA House activities.

 d. Contrary to some initial fears, specialty delegates have not voted as a bloc on any issue, but have generally expressed views similar to state society delegates.

9. In Georgia, there are additional reasons for specialty society representation in the MAG House:

 a. State specialty societies feel that by working within the MAG House, they could better advance their interests and the interests of organized medicine in general. Some specialty societies have also stated that House representation would improve communication among the various state societies.

 b. Specialty societies also believe that House representation would lead to increased MAG membership.

 c. Some specialty societies routinely have no mem-

ber to attend the House as a county medical society delegate. A specialty society delegate would be able to participate in the House proceedings and report on them directly back to his colleagues.

d. Several societies feel that their relations with the MAG could be greatly improved through specialty society representation.

On this basis we recommend that the Medical Association of Georgia add to its House of Delegates one delegate and alternate delegate from each state specialty society recognized by the MAG Interspecialty Council.

Reasons

1. Under the current format of the MAG House, a delegate is not responsible to his specialty society. Communication between the MAG and the specialties has suffered as a result.
2. Under the current format, some specialties are considerably underrepresented, some are overrepresented, and some have no representation at all.
3. Almost all of Georgia's specialty societies are strongly in favor of direct representation in the House.
4. Almost half of all state medical associations have added specialty society delegates to their Houses of Delegates.
5. The AMA has concluded that specialty society representation in its House is working well and has benefited all parties.

IMPORTANT NOTE: On November 12, 1982, the MAG Executive Committee approved this recommendation and directed the Constitution and Bylaws Committee to present the necessary amendments to this House of Delegates.

On January 8, 1983, the MAG Board of Directors approved this recommendation and directed that it be brought to the House of Delegates.

As chairman, I wish to thank the members of this committee for their support and service: Tommy H. Jordan, Gainesville; E. Daniel DeLoach, Savannah; Samuel S. Ambrose, Jr., Atlanta; and Andrew T. McRae, Valdosta.

Recommendation

That the Medical Association of Georgia add to its House of Delegates one delegate and alternate delegate from each state specialty society recognized by the MAG Interspecialty Council.

House Action

Adopted the Recommendation as amended by addition of the following: ". . . and that the guidelines of the AMA House and Board of Trustees be adopted by the MAG Board of Directors for admission of the specialty society."

Resolution 11

Hospital Staff Privileges

F. William Dowda, M.D., Delegate
Medical Association of Atlanta

RESOLVED, that it is the feeling of the Medical Association of Georgia that the hospital is a necessary element in the practice of medicine and that admission to the medical staff should be on the basis of medical and moral qualifications alone and should not be used as a weapon to prevent a physician from moving into town and practicing in a complete fashion (i.e., with hospital privileges) in that town. This statement in essence is in support of open hospital staff.

House Action

Adopted as amended: RESOLVED, that the MAG recognize the importance of the issue of "open" versus "closed" hospital medical staffs, and direct that this issue be researched by the MAG Medical Practice Committee, which shall report its findings to the House of Delegates in 1984.

Resolution 19

Federal Trade Commission

Medical Association of Atlanta

RESOLVED, that the MAG House of Delegates urge the AMA to undertake, through its executive officers and staff, a nationwide effort to educate the public as well as political leaders as to the value of professional regulations at the state and local levels, and be it further

RESOLVED, that the value of professional self regulation in the form of accreditation of educational programs, accreditation of health care institutions, certification of health care institutions, certification of entry level competence of members, and peer review activities to assure quality services at reasonable charges as well as regulation of unethical conduct by the professions themselves rather than a poorly informed national regulatory agency is to be preferred, and, be it further

RESOLVED, that it again be a major goal of the American Medical Association in 1983 to seek relief through appropriate legislative action from the Federal Trade Commission abuses.

House Action

Adopted.

Resolution 23

Hospital Medical Staff Responsibilities Medical School Curriculum

Hospital Medical Staff Section

RESOLVED, that the Hospital Medical Staff Section recommend to the House of Delegates of the Medical Association of Georgia that the teaching programs throughout the State of Georgia be encouraged to incorporate into their curriculum orientation to the credentialing process, quality assurance, contractural relationships and the responsibilities of medical staff membership.

House Action

Adopted.



COVEY RISE

Covey Rise Farm is a 340 acre private hunting preserve. Two ponds, fields, streams and woods provide a habitat for deer, dove, duck and quail. Handsomely restored, this 1880 Victorian has 3 bedrooms, 3½ baths and 8 fireplaces. There is also a 2 bedroom guest cottage and caretaker's home. $575,000.



AUGUSTA

Sky Meadows is a luxurious 105 acre country estate just 13 miles from Downtown Augusta, Georgia. A reflecting lake and fenced pasture lands lie on either side of the private tree-lined road that leads to this elegant 5,100 sq. ft. home. There is a riding ring and an 8 stall horse barn with tack and feed rooms and barn office. $795,000.



CARROLLTON

Blue Georgia skies, tall pine and 336 acres of fenced pasture and woodlands surround this fine Southern Colonial home. There are 4 bedrooms, 4½ baths and a pleasing combination of comfort and elegance within its 4,700 sq. ft. The entertainment area outside has a 20'x40' pool and a gazebo. Acreage may vary as follows: On 10 acres-$275,00; on 197 acres-$545,000; on 336 acres-$750,000.



THOMPSON
CATTLE RANCHES

323 acre cattle ranch with small well-kept older home, 3 small lakes on property, 1/3 of land in timber and the rest in cattle grazing grasses. $315,000. 630 acres of cattle land - 30 acre lake and small lake, ½ of land in timber and ½ in grazing grasses and cropland. $585,000.



CANTON

Gorgeous Georgian Brick Colonial in Canton on 15 beautifully wooded acres high above the Etowah River. More than 4,150 sq. ft., built in 1921, this two-story classic has 5 bedrooms, 3 baths, 8 fireplaces and hardwood floors. It is located in a park-like setting with a sweeping drive to the top of the hill. $350,000.



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A Cumberland Island home is one of the world's most exclusive properties. Protected benefits accrue from its status as a National park - controlled access and daily ferry service. This 7½ acre estate consists of a furnished 3 bedroom home, caretaker's cottage and deep water dock. This 29 year lease-hold may offer tax advantages to a corporation, a partnership or syndication. $375,000.

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Report of Reference Committee F

Cyler D. Garner, M.D., Chairman
C. Peter Lampros, M.D., Vice-Chairman

The following persons served on Reference Committee F: Cyler D. Garner, chairman, Gordon; C. Peter Lampros, vice-chairman, Toccoa; C. Emory Johnson, Jr., Macon; Archie J. Morris, Vidalia; Luther Thomas, Augusta, Jeffrey T. Nugent, Atlanta; and Marvyn Cohen, Columbus.

Treasurer
James H. Sullivan, M.D.

The House of Delegates in April, 1980, voted to accept the recommendation of Earnest C. Atkins, M.D., in his President's Report "that there should be no dues increase for MAG members until the liquid, unrestricted funds of the Association are reduced to one-half (½) of the amount budgeted for expense in the year's budget under consideration, and that these funds be spent only by recommendation of the Finance Committee of the Board of Directors."

The budget presented to the Finance Committee, Reference Committee "F," and the Executive Committee this March for the 1983-1984 fiscal year amounted to $1,957,933, with a projected income of $1,630,667, leaving a deficit of $327,266. Our liquid, unrestricted fund in the bank is $1,078,956.31, which must last us through October, 1983. We are in the position of needing a dues increase due to our deficit, but the amount for expenses projected is $199,997 short of Dr. Atkins' criteria. I feel that some of the cuts made by the Finance Committee will be put back into the budget, increasing our deficit. At this rate of spending, MAG could be without funds in about three (3) years. I feel that we must have a dues increase of $75 per year to carry us through the coming year, and I so recommend.

I have one more year as treasurer of the MAG, and I certainly do not wish to leave the Association in financial straits. It would not be fair to the new officers and the new Finance Committee. A poor cash position would limit any projects or services to the Association membership which are presently being provided. It is nice to be able to tell you that we have come a long way, from a $600,000 budget to almost $2,000,000 in our time, due mainly to inflation.

The dollar today is worth only 66% of what it was in 1977, the date of our last dues increase. MAG is in good financial condition at this time, but with plans to expand our services to our patients and our members I feel that the dues increase should be voted beginning with the billing in November, 1983.

The Association staff worked very hard to help get MAG Mutual on their feet. MAG Mutual was a baby born at MAG, and has suddenly become the Big Daddy. The company is doing well, writing more insurance every day. The officers of MAG Mutual did not see fit to let MAG do their computer work for them, voting instead to buy their own computer. Their decision was based on timing, and because of the problems encountered by both sides as far as the programming and service was concerned. MAG will not only be losing the majority of the computer services, but we also will have a lease loss of the downstairs portion of the MAG building when MAG Mutual moves in December of this year. This is a growth move, intended to keep MAG Mutual well supervised and growing.

We must plan for the future, either by expanding our present building, or wait for MAG Mutual to buy a building with MAG renting from them and sell the present MAG building at the right moment.

The legislative effort this year was very good, and every physician who helped deserves a pat on the back, either for Doctor of the Day or the Physician Involvement Program. A doctor's presence at the Capitol during the legislature does make a difference.

The *Journal* continues to show improvement, with advertising still on the up side.

The *Newsletter* keeps you informed as to just what is going on. Many new problems, governmental and otherwise, are having to be faced by the private practitioner every day, and your Association is endeavoring to make you aware of these problems and just what we advise doing about them.

Your Headquarters building has been beautifully remodeled upstairs with an elevator installed. In October of 1984, we will pay our last note on this building. The neighborhood is improving, and the property value should be rising, as the Tenth Street Marta Station is now in operation.

We have word processors to help our staff do the best possible job, and our Xerox is still holding up well enabling us to cut copy costs.

Please continue to help MAG Mutual — buy your insurance coverage from them. These two corporations need to remain close in a joint effort to serve every member of MAG. The second of my recommendations to the House of Delegates is to encourage MAG Mutual to give MAG's computer department just as much business as possible.

Please continue to cooperate with the Georgia Medical Care Foundation, the Peer Review arm of the MAG. The PRO is funded through June, 1984, and after this a private review will be instituted. Mr. Bob Wesley is doing a good job, and we need to plan for this worthy organization to continue. We hope to do their computer work for them, meeting their needs to the fullest.

The Public Relations Department has been given seed money for massive exposure of our activities aimed at our patients and physician members in 1983-1984.

We are very happy that Mrs. John G. Bates (Glenda) of Cuthbert, Georgia, is to be installed as President of the Auxiliary to the American Medical Association. Congratulations!

With the AMA membership from Georgia exceeding 5,000, we now have a sixth Delegate to the AMA. MAG is doing quite well at the AMA, as our own Jack Rogers, present Speaker of the AMA House of Delegates, will be running for President-Elect of the AMA in 1984. Dr. Bill Dowda is a member of the AMA Board of Trustees. And

Dr. J. Rhodes Haverty has been nominated for membership on the AMA Council on Medical Education.

We are budgeting $56,425 to the Auxiliary to the Medical Association of Georgia this year, and I would like to recommend to the House of Delegates that the Auxiliary be encouraged to increase their dues from $4 per year to a more reasonable and realistic figure.

We have seen the tremendous rise in inflation, with accompanying increases in local, state, and federal taxes, especially Social Security. We also see decreases in Medicare and Medicaid benefits, proof that our national politicians are capable in creating health care problems, *only*.

It is a pleasure to serve the MAG as its treasurer, and I would like personally to thank Mr. L. B. Storey for his dedication and attitude toward the MAG. He makes being treasurer an enjoyable chore.

May I also thank the Finance Committee, the Executive Committee, the members of Reference Committee "F," the Board of Directors, and the entire membership of the Association for their help in keeping MAG financially sound.

Recommendations

1. That MAG dues be increased by $75 per year to carry us through the coming year.
2. That the Auxiliary to the Medical Association of Georgia increase its dues from $4 per year to a more reasonable and realistic figure.

House Action

Recommendation 1 — not adopted, but House advised that a dues increase can be expected in 1984 due to the large deficit budget for 1983-84. Recommendation 2 — Not adopted, but House congratulated the Auxiliary for their support of the MAG.

Report of the Board of Directors — MAG Budget, 1983-1984

Jack A. Raines, M.D., Chairman

Income	*1983-1984 Proposal*	*Actual '82-'83 Estimated to May 31*
Membership Dues	$1,014,550	$ 994,995
Journal Advertising Sales	100,000	98,629
Cancer Registry	107,000	32,903
Prison Health Care	40,484	32,558
Ga. Society of Ophthalmology	21,704	16,864
Internal Medicine & ENT		327
Risk Management Seminars	8,000	12,078
Educational Seminars		9,427
MAG Leadership Conference	7,000	
Subscriptions, *Journal*	5,500	4,921
Subscriptions, *Newsletter*	300	305
AMA Refund	5,000	6,536
Data Processing Fees	225,529	220,334
Interest Income	80,000	91,228
Rental Income	15,000	32,000
Miscellaneous Income	600	204,158
Total Income	$1,630,667	$1,757,263

Administrative	*1983-1984 Proposal*	*Actual '82-'83 Estimated to May 31*
Salaries	$ 442,108	$ 445,398
Health Insurance	46,079	45,606
Disability Insurance	4,560	4,208
FICA Tax	28,535	28,713
Unemployment Tax, State	2,246	1,881
Unemployment Tax, Federal	1,512	1,144
Retirement	29,684	25,730
Recruitment	50	
Legal Fees	25,000	24,600
Legal Expense	750	742
WATS — Outward	5,500	4,828
WATS — Inward	7,000	7,639
Telephone	27,000	28,240
Postage	25,000	23,944
Staff Travel	25,000	26,800
Printing	2,600	
Dues & Subscriptions	1,800	1,628
Data Base Maintenance	5,500	7,915
Audit	5,000	5,000
Office Supplies	11,000	10,500
Xerox Maintenance	1,245	1,320
Payroll Charge — Computer	1,200	
Retirement Trust Fee	1,000	1,240
Labels — Computer	500	365
Car Allowance — Executive Director	3,480	3,480
Equipment Maintenance	8,565	8,083
Consultant	62,863	
Total Administrative	$ 774,777	$ 709,004

Expenses	*1983-1984 Proposal*	*Actual '82-'83 Estimated to May 31*
Membership		
Travel — President	$ 5,830	$ 5,260
Travel — President-Elect	3,090	2,417
Travel — Past President	3,090	649
Travel — AMA Delegates	23,898	14,322
Caucus Breakfasts	1,800	1,468
Headquarters Suite	3,800	3,462
Southeastern Coalition	2,900	1,530
Travel, Sec. & Treasurer to AMA	2,630	1,483
2 MD's to AMA Leadership Conf.	1,500	1,649
AMA MSS — Annual Session		
AMA MSS — Travel	2,740	
State Medical Education Luncheon	350	371
Sundry	500	446
Executive Committee Provisional	6,000	248
Executive Committee Travel	5,500	5,672
Business Coalition	4,000	8,000
Meetings	4,000	5,124
President's Provisional Fund	24,000	18,942
Roster	9,500	10,781
Proceedings Issue	3,000	3,137
Total	$ 108,128	$ 84,961

Information Systems		
Salaries	$ 94,902	$ 106,854
FICA	5,836	7,031
Health Insurance	9,213	7,834
Retirement	5,872	8,164
Insurance, Equipment	500	500
Equipment Rental	28,500	40,700
Equipment Maintenance	21,500	29,028
Data Communication	1,800	1,778
Service Contracts	5,000	18,451
Supplies — Durable	2,400	4,571
Supplies — Expendable	10,600	9,600
Software — Documentation	2,400	1,200
Installation & Site Prep.	1,000	2,767
Depreciation — Equipment	24,000	24,000
Travel	3,000	3,690
Education, Dues, Subscriptions	2,500	1,600
Consulting Fees	1,000	650
Temporary Help	200	
Recruitment	50	
Office Operation	5,016	4,873
Total	$ 225,289	$ 273,273

* Equipment Purchases $6,500

Expenses

	1983-1984 Proposal	*Actual '82-'83 Estimated to May 31*
Building Expenses		
Interest on Mortgage	$ 5,124	$ 7,300
Building Maintenance	7,500	7,241
Janitorial Service	15,300	16,480
Insurance — Casualty	7,000	6,100
Utilities	26,000	26,480
Depreciation — Building	22,300	22,300
Depreciation — Equipment	27,828	27,828
Ad Valorem Tax	22,430	21,700
Total	$ 133,482	$ 135,429
Journal		
Salaries	$ 35,750	$ 32,084
Health Insurance	3,438	3,269
FICA	2,178	1,891
Retirement	2,190	1,623
Printing	63,110	76,450
Photo Processing	150	122
Advertising — Promotion	300	364
Postage & Copyright	7,800	7,968
Clipping Service	350	296
Dues, Subscriptions	200	135
Artwork	3,600	4,460
Mailing Labels	400	656
Travel	800	1,562
Total	$ 120,266	$ 130,880
Other		
Retainer — Franklin	$ 3,600	$ 3,600
AMA Reception with Illinois	2,500	
AAMA President Gift — Mrs. Bates	500	
Board of Directors' Contingent	160,000	141,780
Total Other	$ 166,600	$ 145,380



L. B. Storey (left), MAG's Director of Finance, and members of Reference Committee F: Luther Thomas, Archie J. Morris, Jeffrey T. Nugent, and C. Peter Lampros, chairman.

Committees & Specialty Societies		
Ga. Society of Ophthalmology	$ 21,704	$ 21,222
Access to Health Care	4,500	2,217
Annual Session	13,765	14,912
Auxiliary	56,425	35,722
Impaired Physicians Program	63,000	62,701
Doctor of Day Program	6,222	3,965
GaMPAC		7,280
Legislation & Bulletin	42,815	33,249
Physician Involvement Program	3,500	2,818
Health Planning	500	
Education	4,820	(933)
Medical Practice	300	2,500
Nutrition	500	500
Peer Review	1,500	296
Prison Health Care	40,484	38,789
Professional Liability Insurance	1,360	748
Public Relations	60,000	13,814
Scientific Assembly	10,310	2,627
Newsletter	11,000	7,713
Third Party Relations	500	
Cancer Registry	107,000	89,700
Leadership Conference (MAG)	12,500	
Ga. Society of Internal Medicine		58
Ga. Society of Head & Neck Surgery		20
Ga. Psychiatric Association		137
Total	$ 462,703	$ 340,055

* Equipment Purchases $5,000

TOTAL INCOME	$1,630,667	$1,757,263
TOTAL EXPENSES	1,991,245	1,818,982
Excess of expense over income	$ 360,578	$ 61,719

House Action

Adopted the Budget with the following amendments: "Expenses, Committees and Specialty Societies: Access to Health Care remain at $4500, and a fee of $10 be charged to non-MAG members for Physician Placement Services; Legislation and Bulletin be increased to $42,815; changing the total of Committees and Specialty Societies to read $462,703. Total expenses of the 1983-1984 Budget be increased to read $1,991,245; and Excess of expenses over income be increased to read $360,578.



Jack Menendez (left), Speaker of the House, Archie J. Morris and C. Peter Lampros, members of Reference Committee F, and Mr. James Moffett, Executive Director of the MAG.

Report of the Board of Directors — B

Dues Increase — House Officers

Jack A. Raines, M.D., Chairman

After an extensive study of our structure by the Membership Committee as it pertains to Resident members and Students, the Membership Committee recommended to the Board of Directors that the current dues of $10 for Resident members be increased to $15 beginning in 1984.

As Residents now are given full rights and privilege as all other members in MAG, the Board concurs with the Membership Committee's recommendation concerning this dues increase. Therefore, we recommend the following:

Recommendation

That Resident dues (House Officers) for MAG membership be increased from $10 to $15 beginning with the 1984 dues year.

House Action

Adopted.

Resolution 24

AMA Dues Increase

F. William Dowda, M.D.
Delegate from the AMA

RESOLVED, that MAG endorses the third leg ($25) of the proposed AMA dues increase.

House Action

Adopted as amended: "Resolved, that MAG instruct its AMA Delegates to approve a dues increase only if it is financially justifiable after careful expense analysis; and that all AMA programs be reviewed and duplications eliminated.

Ridgeview Institute

Ridgeview Institute is a private, nonprofit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

Award winning in its architectural design, Ridgeview is housed on 40 acres of land with lighted tennis and volleyball courts, swimming pool, and a fully equipped gymnasium for supervised sports and physical education programs.

Adult Chemical Dependency

The Adult Chemical Dependency Program offers a unique and innovative treatment modality that includes inpatient treatment and an emphasis on aftercare. The staff views alcohol and drug dependency as a primary disease that affects a person physically and psychologically.

The seven element program includes medical, educational, and family therapy, Alcoholics Anonymous and Narcotics Anonymous, group psychotherapy, non-chemical coping skills and spiritual counseling.

Adult Psychiatric Treatment

The Adult Psychiatric Program at Ridgeview provides specialized treatment for persons suffering from depression, anxiety, schizophrenia, manic-depressive disorders, personality disorders, and other similar dysfunctions.

Under the psychiatrist's leadership, treatment is specifically designed for each patient's particular needs in order to promote a productive return to family, job, and community as early as possible.

Adolescent Treatment Services

The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

Ridgeview INSTITUTE

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"...particularly effective in soft tissue disorders including sports injuries,"[1] Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.

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Pioneers in medicine for the family

See next page for brief summary of prescribing information.

Measure RUFEN® (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."[2]
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.[3]
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."[4]

Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
• powerful treatment of both pain and inflammation	• virtually no treatment of the inflammatory component
• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	



References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
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3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesic. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.

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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). Central Nervous System: dizziness*, headache, nervousness. Dermatologic: rash* (including maculopapular type), pruritus. Special Senses: tinnitus. Metabolic: decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. Central Nervous System: depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. Dermatologic: vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. *Special Senses:* hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. Hematologic: neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. Cardiovascular: congestive heart failure in patients with marginal cardiac function, elevated blood pressure. Allergic: syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). Renal: acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. Miscellaneous: dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. Central Nervous System: paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. Dermatologic: toxic epidermal necrolysis, photoallergic skin reactions. Special Senses: conjunctivitis, diplopia, optic neuritis. Hematologic: bleeding episodes. Allergic: serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis. Endocrine: gynecomastia, hypoglycemia. Cardiovascular: arrhythmias (sinus tachycardia, bradycardia, and palpitations). Renal: renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. *Do not exceed 2,400 mg per day.*

CAUTION: Federal law prohibits dispensing without prescription.

Final General Session

Saturday, April 23, 1983



Outgoing President Charles D. Hollis, Jr., passes the gavel and medallion as symbols of leadership to MAG's incoming President, William W. Moore, Jr., of Atlanta.

President Charles D. Hollis, Jr., convened the Final Session of the 129th Annual Business Meeting of the Medical Association of Georgia at 5:21 PM on Saturday, April 23, 1983, in the Dining Gallery of the Columbus Convention and Trade Center.

Installation of Officers

President Hollis installed the following elected officials:

President — William W. Moore, Jr., Atlanta
President-Elect — S. William Clark, Jr., Waycross
Second Vice-President — John D. Watson, Columbus
Judicial Council — Robert B. Copeland, LaGrange
Judicial Council — C. Emory Bohler, Brooklet
AMA Delegate — C. Emory Bohler, Brooklet
AMA Delegate — H. Hilt Hammett, Jr., LaGrange
AMA Delegate — William W. Moore, Jr., Atlanta
AMA Delegate — Charles D. Hollis, Jr., Albany
AMA Alternate Delegate — C. Peter Lampros, Toccoa
AMA Alternate Delegate — Carson B. Burgstiner, Savannah
AMA Alternate Delegate — S. William Clark, Jr., Waycross
AMA Alternate Delegate — James H. Sullivan, Columbus
AMA Alternate Delegate — L. Newton Turk, III, Atlanta
Sixth District Medical Society Director — Samuel L. Brewton, Thomaston
Sixth District Medical Society Alternate Director — Norman P. Gardner, Thomaston
Seventh District Medical Society Director — Bannester L. Harbin, Rome
Seventh District Medical Society Alternate Director — John Atha, Rockmart
Dougherty County Medical Society Director — Frank F. Middleton, III, Albany
Dougherty County Medical Society Alternate Director — Carl V. Hancock, Albany
Hall County Medical Society Director — John Reed, Gainesville
Hall County Medical Society Alternate Director — James Leigh, Gainesville
Medical Association of Atlanta Director — William C. Collins, Atlanta



Being sworn in to newly elected positions are (L-R), William C. Collins, Atlanta, MAA Director; John Atha, Rockmart, 7th District Director; E. M. Molnar, Columbus, MCMS Alternate Director; William W. Moore, Jr., Atlanta, President; Jack A. Raines, Muscogee, MCMS Director; James A. Kaufmann, Atlanta, Vice-Speaker; and C. Peter Lampros, Toccoa, AMA Alternate Delegate.



Joe Nettles, of Savannah, is the new Chairman of MAG's Board of Directors.

Medical Association of Atlanta Alternate Director — Bob G. Lanier, Atlanta
Muscogee County Medical Society Director — Jack A. Raines, Columbus
Muscogee County Medical Society Alternate Director — E. M. Molnar, Columbus

President Hollis passed the gavel and medallion as symbols of leadership to the incoming president, William W. Moore, Jr., of Atlanta. Dr. Moore then presented Dr. Hollis with the MAG President's pin, a bound set of the *Journal of the MAG* encompassing his presidential year, and a silver gavel appropriately inscribed.

Dr. Moore announced the dates and sites of future MAG House of Delegates meetings as follows: 1984, Atlanta, April 26-29, Monarch Plaza; 1985, Savannah, April 24-27, Hyatt Regency; 1986, Callaway Gardens, April 24-27, Callaway Gardens Inn.

Dr. Moore then announced the official attendance of the 129th Annual Session as follows: Delegates, 169; Alternate Delegates, 19; Members, 22; Guests, 34; Auxiliary, 164; Students, 10.

Adjournment

Dr. Moore announced the 129th Annual Session of the Medical Association of Georgia adjourned at 5:30 PM.

DR. COLLINS ISN'T PAYING HIS MALPRACTICE INSURANCE PREMIUM THIS YEAR.

But he'll still be covered. Because the Army covers it. Jack Collins is an Army surgeon. And he doesn't have to burden himself with the details of running a civilian surgical practice. The Army does the worrying for him.

It works out better for Dr. Collins. And for the Army. He has a relatively trouble-free practice. And the Army has a first-rate surgeon.

Every Army physician is commissioned as a Captain or higher. He earns 30 days paid vacation a year. And his noncontributory retirement benefits are substantial.

Jack Collins joined the Army to practice surgery. . .not bookeeping, typing, accounting, or hiring office help. Army medicine is as free from nonmedical distractions as it is possible for any practice to be.

The Army Medical Department has positions available or projected requirements for physicians trained in the following specialties in the Southeastern United States.

GENERAL SURGERY
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ORTHOPEDIC SURGERY
OBSTETRICS-GYNECOLOGY
OTOLARYNGOLOGY
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CHILD PSYCHIATRY
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FAMILY PRACTICE

If you desire an attractive alternative to civilian practice for a reasonable net amount of money and want to spend a reasonable amount of time with your family, then maybe you should find out more about Army Medicine.

To obtain more information on eligibility, salary, and fringe benefits, write or call collect:



AMEDD Personnel Counselor
HQ, US Army Forces Command
Building 128
Fort McPherson, GA 30330 (404) 752-3611



President's Reception

Saturday, April 23, 1983



Dr. and Mrs. Charles D. Hollis, Jr., of Albany.

Outgoing President Charles D. Hollis, Jr., welcomed the MAG Delegates, Alternate Delegates, members, guests and friends, to the President's Reception for the 1983 Annual Session.

MAG Awards

Dr. Hollis presented the 1983 MAG Distinguished Service Award to Carson B. Burgstiner, Savannah. Dr. Hilt Hammett accepted the award in Dr. Burgstiner's absence.

Dr. Hollis then presented the 1983 MAG Award for Civic Endeavor to Linton H. Bishop, Jr., Atlanta.

To present the 1983 MAG Award for Family Practitioner of the Year, Dr. Hollis called on David S. Sowell, President of the Georgia Academy of Family Physicians. Dr. Sowell presented the Family Practitioner of the Year Award to Frank M. Houser of Macon.

William W. Moore, Jr., President of the Medical Association of Georgia, then delivered his inaugural address.



Frank M. Houser, of Macon, was the 1983 recipient of MAG's Family Practitioner of the Year Award.



Linton H. Bishop, Jr., of Atlanta, is presented with the 1983 MAG Award for Civic Endeavor by Dr. Charles Hollis.



WANT TO KILL A CONVERSATION? JUST MENTION COLON AND RECTUM CANCER.

WELL, NICE TALKING TO YOU, BUT I GOTTA GO.



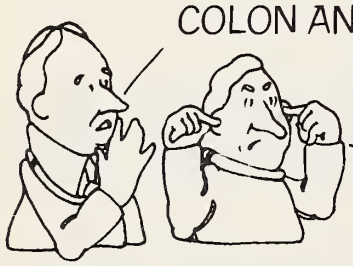
SEE? EVEN THOUGH CANCER OF THE COLON AND RECTUM IS SECOND BY THIS MUCH TO LUNG CANCER...

SERIOUSLY, I DON'T WANT TO DISCUSS IT.



AND IT'S ONE OF THE MOST TREATABLE KINDS OF CANCER. STILL...

I DON'T WANT TO TALK ABOUT IT.



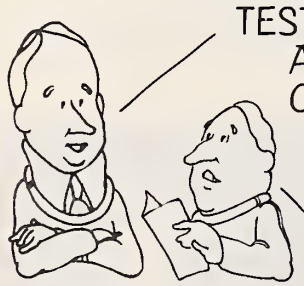
COLON AND RECTUM CANCER IS THE CANCER NO ONE WANTS TO TALK ABOUT.

TELL ME WHEN YOU'RE FINISHED.



SO IF YOU DON'T WANT TO TALK ABOUT IT, MAYBE YOU'LL READ ABOUT IT. HERE.

HUH?



THAT LITTLE BOOKLET TALKS ABOUT A SIMPLE, PRACTICAL TESTING PROCEDURE...ABOUT THE IMPORTANCE OF EARLY DETECTI AND TREATMENT...ABOUT HOW TODAY COLON AND RECTUM CANCER DOESN'T NECESSARILY MEAN A COLOSTOMY. IN SHORT, IT TALKS ABOUT SAVING LIVES AND SAVING THE QUALITY OF THOSE LIVES.

AMAZING!



BUT WHY DIDN'T WE TALK ABOUT THIS BEFORE?

LET'S TALK. For a free booklet on colon & rectum cancer, contact your local ACS office.

American Cancer Society

This space contributed as a public service.

The Bradley Center

For Personal Problem Resolution and Growth

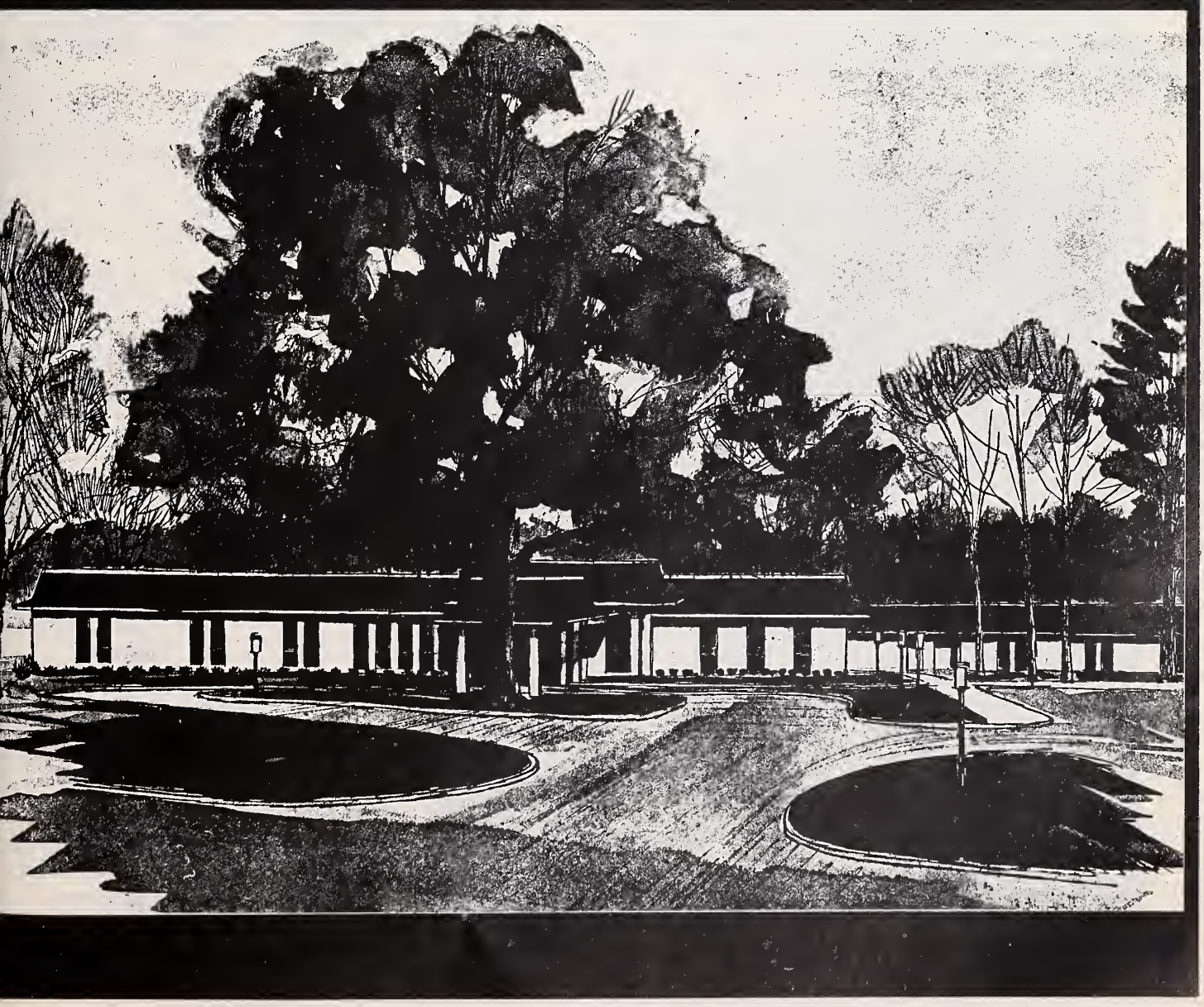
The Center offers a broad spectrum of clinical services including inpatient, day treatment, and outpatient programs. Individuals, couples, and families are provided an opportunity for multiple psychotherapeutic encounters. A dynamically oriented staff, representing all the major mental health disciplines, allows the flexibility necessary to design a treatment approach consistent with the unique need of each individual.

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ANNOUNCING TWO NEW ROCKERS FROM THE ROCKER SHOP[S.M.]

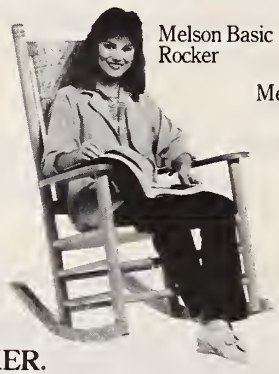
The Melson Standard Rocker and the Melson Basic Rocker. Both set a standard for superior quality. At the Rocker Shop we construct each and every one of our magnificent traditional rockers entirely by hand with tools and techniques that probably can't even be found anymore... except perhaps in museums. From the hand balancing of each rocker through the hand weaving of cane seats and backs to the final assembly and hand sanding, each chair is created to a standard set over 100 years ago.

The materials used in our rockers are as fine as the skills that go into making them. In an era of labels reading "wood products" or "plastic laminates" each of our rockers and accessories is made of beautiful mature oak, selected with painstaking care from an ever-diminishing supply. We both kiln dry and air dry this fine oak, then blend the two for strength and flexibility. The cane used in our double-woven seats and backs is the finest available for comfort and durability. And, if that cane isn't available, we simply stop making our chairs till the next harvest comes in.

Now you can enjoy the quality and heritage of Melson Rockers in two styles. Our Melson Standard offers you traditional turnings, full-sized comfort and stability. Backs are curved to cradle your back with firm yet comfortable support. The Melson Basic is a new interpretation of the traditional rocker ideal for today's homes and apartments. Its clean, straight lines blend well in country, traditional or contemporary surroundings.

Whether you choose the Melson Standard or the Melson Basic, you'll find both still created with the quality craftsmanship and fine materials you thought were a thing of the past.

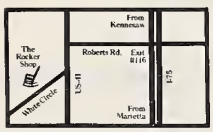
Good things are hard to find, but always well worth the search. Families throughout the country have been seeking out the quality we put into every one of our rockers for over 100 years. Come see why. Visit The Rocker Shop soon. Or, drop us a note, and we'll send you our newest brochure.



Melson Basic Rocker



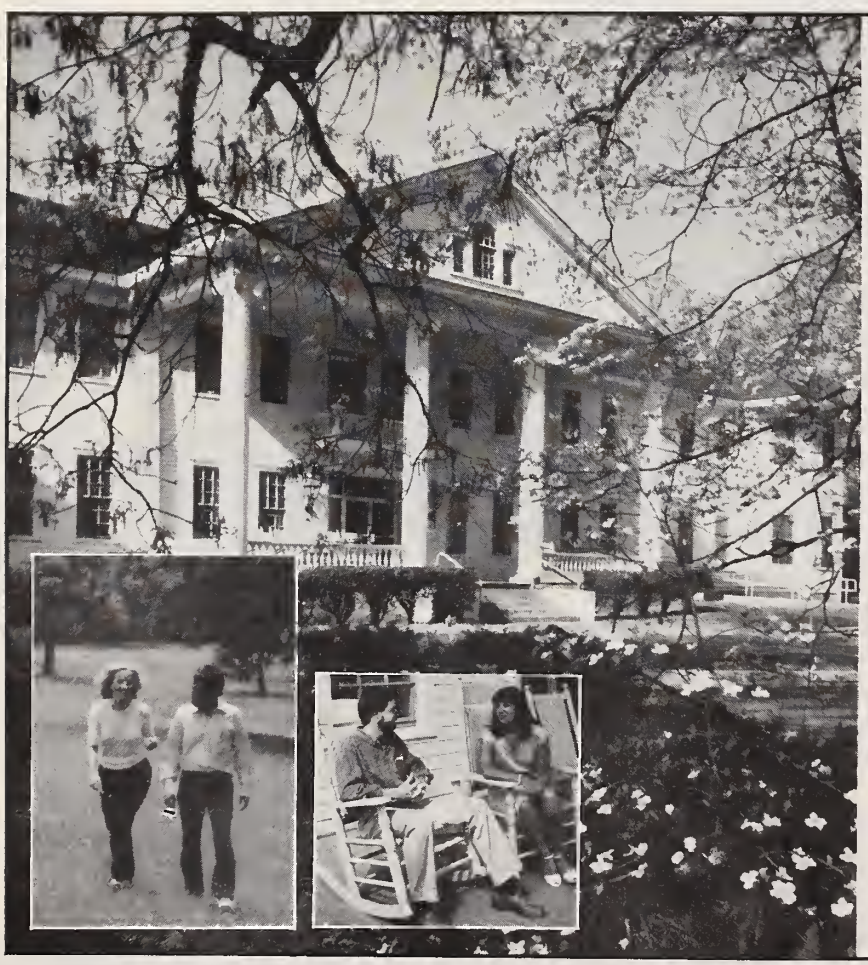
Melson Standard Rocker



The Rocker Shop of Marietta, Georgia™

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Telephone (404) 427-2618

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Although preadmission consultation is preferable, 24 hour staffing by psychiatrists allows emergency admissions at any time.

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PHYSICIAN WANTED

Medical Director (M.D.), part-time position, needed by rapidly growing, progressive IPA-model ("open-panel") HMO based in Atlanta. Responsibilities include management of Peer Review/Utilization Review Program. Liaison between Physician Board and Medical Plan, as well as individual providers. The candidate should preferably be a primary care physician (I.M., F.P., O.B., PED.). Salary/hours negotiable. Send curriculum vitae to Box 6-B, c/o *Journal*.

Physicians Wanted — Family practitioners wanted in Alabama and Mississippi for immediate openings in select clinics with hospital adjacent. Top fringe benefits. First year salary guarantee with early partnership. For complete details contact Charles D. Alderman (601) 483-0011.

Emergency Medicine: Weekend and evening positions available in two emergency departments located northwest of Atlanta. Competitive income and professional liability insurance provided. For details call or write in confidence: Ms. Katie Sherrill, Spectum Emergency Care, Inc., 1111 N. Westshore Blvd., Ste. 211, Tampa, FL 33607; 1-813-870-2356.

Industrial clinic needs physician for large facility located in Atlanta, Georgia area. Prefer Board certified in occupational medicine, family practice or emergency medicine. Competitive salary with good fringe benefits, etc. Please reply, giving complete resume and recent photograph to Box 5-A, c/o Journal.

Position Available — The Department of Neurology of Emory University School of Medicine has a full-time academic position available September 1983 as Deputy Chief of the Neurology Service, Grady Memorial Hospital, Atlanta, GA. The appointment is at the level of assistant professor. The position involves participation in an active patient-care, teaching, and clinical research program based in a center-city hospital which is a major element in the teaching program and community services of Emory University School of Medicine. Clinical competence and teaching ability are essential. Special and research interests are highly desirable as is training and experience in internal medicine. Laboratory space is available for clinical research. Emory University is an affirmative action and equal opportunity employer. Deadline for application is July 15, 1983. For information write: Herbert R. Karp, M.D., Professor and Chairman, Department of Neurology, Emory University School of Medicine, 69 Butler Street, SE, Atlanta, GA 30303, (404) 588-4013.

FOR SALE

Totally equipped office for sale. Doctor retiring. Equipped for family practice or internal medicine. Vidalia, GA. 50,000 people trade area. Available immediately. Box 1107, Vidalia, GA 30474.

Thriving practice and equipment for Family Practice and Geriatrics. Nursing Home Director. Building available reasonable. Located in southeast Georgia. Good climate year-round. Reply to Box 6-A, c/o *Journal*.

Burled-walnut office desk and credenza by John Widdicomb. Desk 72″, credenza 104″. Two years old. Cost new $9500. Best offer. Call (404) 377-7072. Decatur, GA. Photo on request.

FOR RENT

For Lease — 1800 Peachtree Street — Palisades West Building, Atlanta. Offering three months free rent. Walking distance to Piedmont Hospital. Easy access to I-75 and I-85. On MARTA line. **Forest Park Medical Center** — 425 Forest Parkway, Forest Park, GA across street from Med-First Clinic. Brand new buildings, first generation space. Highly visible location, daily traffic count is 23,320 cars. In commercial heart of fast-growing Clayton County. Easy access to I-75 and I-285. **Tucker Medical Center —** 2088 Idlewood Road, Tucker, GA. Next door to Doctor's Hospital. Quality building and landscape. Reasonable rent. **Magnolia Medical Center —** 2965 Johnson Ferry Road, Marietta, GA. Located in heart of growing East Cobb County. Brand new building — first generation space. Excellent exposure — daily traffic count is 12,397 cars. Only one suite still available. All of the above buildings offer: On-site ownership and management; generous build-out allowance; custom design your space; free parking. Contact Lucien B. Lane, Sharp-Boylston Co. (404) 522-2929.

Outstanding Practice Location — The professional center is located in the heart of Clayton County's medical sector. Tremendous growth potential for new or existing practice. Excellent location in a densely populated area. Convenient to major highways and ½ mile from Clayton General Hospital. 1,000 sq. ft.-3,750 sq. ft. available to prelease. Contact: Lynda Saunders, Devin Management Co., Inc. (404) 493-6311.

Pediatric Practice — Lucrative, established, and growing practice, located in N.E. Atlanta. Excellent lease in medical complex near 3 large hospitals. Good coverage available. Reply to P.O. Box 450881, Atlanta, GA 30345.

Riverdale Area — Furnished office space available for part-time private practice, new or second office. Hugh A. Christie, Ph.D., (404) 991-1711 or (404) 228-9317.

SITUATION WANTED

Share Office — Private doctor's office (13 × 10), 3 full-size exam. rooms (8 × 10), (8 × 10), (9 × 10), separate bathroom, separate business office, share waiting room and lab. Ideal location beside DeKalb General Hospital. If interested contact: Alvin Blumenfeld, MD, Ste. B-110, 495 Winn Way, Decatur, GA 30030. Phone: (404) 292-6060.

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JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, GA 30309-3990

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations must be submitted in duplicate. Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, GA 30309-3990.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

JOURNAL of the medical association of georgia

JULY/1983

medical arrives in time

Seabrook

ewlon, 52, of Lithonia saw a story over the wee... which hundreds of doc... d started a ne... ree medical car... o have no insur... lay, the day th... lled Operation C... wlon was having... perate to get him... night qualify for the ... the number — ... program.

olunteers manning ... one lines checked their ... s of doctors who had volunteered to le the medical care at no cost. New- as referred to Dr. Russell Kramer, a oenterologist.

"It sounded like he need... y, and I told h...

eration Care' Meeting edical Needs Of Jobless

...ere, he was placed ...ntensive ...are of Dr. Stuart J. Topor...

"The response to the new prog... been overwhelming," said Ken ... spokesman for the Medica... Georgia.

It was the associatio... Operation Care, a non-pr... More than 400 physician... have volunteered to pro... at no cost as pa...

In order... persons mu... Jan. 1...

Local Jobless Offered Free Medic...

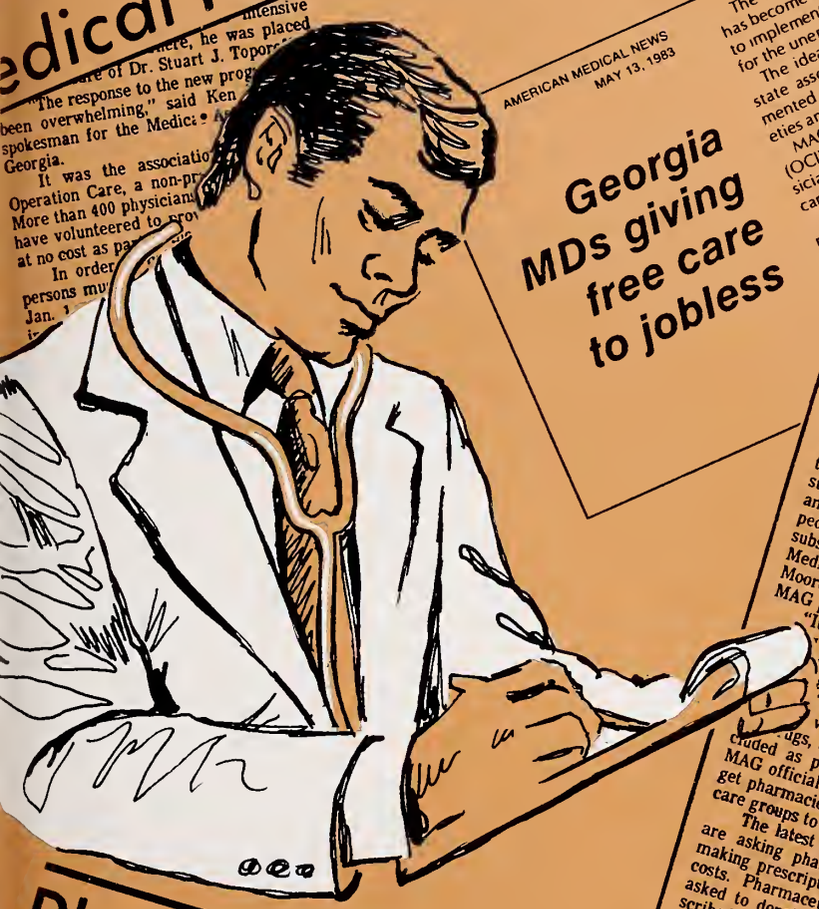
The Medical Assn. of Georgia has become the first state medic... to implement a free medical ca... for the unemployed.

The idea has been end... state associations and ... mented by several co... eties and specialty ... MAG's program ... (OCI), has enli... sicians in all s... care.

The p... ro-Atla... their ... un...

AMERICAN MEDICAL NEWS MAY 13, 1983

Georgia MDs giving free care to jobless



The Atlanta Journal

FRIDAY EVENING, APRIL 29, 1983

Metro doctors offer free care to unemployed

By Charles Seabrook
Staff Writer

Hundreds of metro Atlanta doctors, concerned that out-of-work patients are delaying seeking medical care because of lack of money, have set up a non-profit corporation to provide free treatment ... unemployed people who cannot pa...

The program, known ... Care Inc., was announ... Medical Association ... ready has signed up ... cians in all specialties ... medical care for people ... "between the cracks" of th... care system.

There are thousands ... metro Atlanta who have lost t... to the sluggish economy, and w... sult, also have lost their health ... and other medical benefits. Howev... people are ineligible for any gove... subsidized medical programs, su... Medicare or Medicaid, said Dr. Willia... Moore Jr., an Atlanta general surgeon ... MAG president.

"It is this group of people we a... to help," said Moore. "These are ... ple that President Reagan de... as having 'fallen between the ... our health care system."

...work, X-rays, medical supplies ...ugs, and hospitalizations are not in... cluded as part of the program, although MAG officials said that they are trying to get pharmacies, hospitals and other health care groups to participate in the program.

The latest MAG newsletter said, "We are asking pharmacists to cooperate by making prescriptions available at reduced costs. Pharmaceutical houses are being asked to donate the most commonly prescribed drugs.

"Major employers are being asked to allow their laid-off workers to be treated by the company physician. In addition, they are being requested to contribute funds for the program."

Also, the newsletter said, since many of the patients will require hospitalization.

provide to Ope... Thus ... has ...

May 8, 1983 opinion Columbus, Ga.

The Sunday Ledger-Enquirer

City Doctors Have a Hear...

As economic health is slowly being restored in America, unemployment is dropping slowly, steadily.

Losing one's job is among the most agonizing of ...periences ... dis- in American life... appear, bills mo... gets worse by... many jobles... themselves w... surance. Oft... ify for ge... medical h... are clin... spect h... and c... Wh... get ... em...

group response to the pro... is indicated.

Therefore, beginning ... day, these physicians w... available to help. Pers... need can call 324-0362. ... society auxiliary volu... will staff the line. The ... be only for non-e... ...ill be only f... their j...

Free Care Offe...

From A-1

CARE — COLUMBUS has been operating i... Jernigan quoted Georgia Labor Departm... mates that about 1,350 of the 6,000 jobless ... in Chattahoochee and Muscogee Counties ... hausted their eligibility for unemployment co... tion. Despite that, the statement said, many ... people cannot qualify for Medicaid or Medicare ... ance because they own some assets — houses, ... money saved for their children's education ... of these people may be described ... although they do not meet ... port from Medica... said.

The Atlanta Journal MAY 3, 1983

State doctors set exam...

The Medical Association of Georgia has distingu... by becoming the first state medical society to ... medical care program to the unemployed. The ... has reacted commendably to the current crisis ... those who are out of work.

...stimated 70,000 unemployed in m... the pilot program will be ... qualify for free car... ...ogram will pr... ...are th...

Physicians Offer Free Care to the Unemployed

THE COLUM... LEDGER Thursday, May 5, 1983

...Groups Aiding ...nsured Jobless

ATLANTA, May 11 — Patric... on, who is 41 years old and ... mother of one, ... ince Mar...

By RONALD SMOTHERS
Special to The New Yo...

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404/549-8700

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912/432-4251

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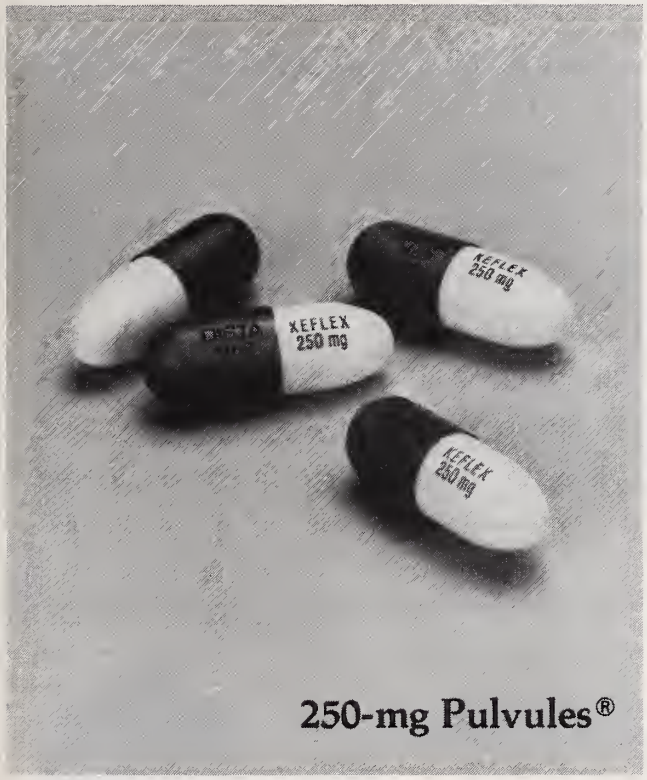
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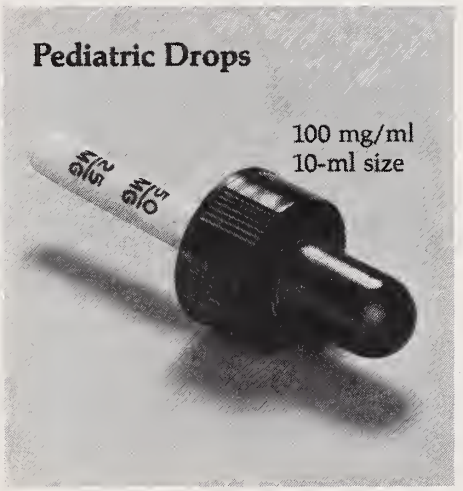
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by
Evelyn Ward Gay

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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Artwork by Richard Lyons, of Richard Heiman Advertising, Inc., Atlanta

Letters to the Editor . . .

"Gonococcus, Gonorrhoeae" — Correct Usage?

Dear Sir,

Under "Incidental Intelligence," p. 238 of April 1983 issue of the *Journal of the Medical Association of Georgia,* you published the rules of Georgia Department of Human Resources, Physical Health — Prophylactic Treatment of the Eyes of the Newborn. Under the heading of 290-5-20-.02 Subparagraph (1), an italicized term of "Neisseria gonococcus" is used. I would like to point out to you that italicized terms are purported to be authentic which this term is not. Please consult Bergey's Manual or any other official microbiology publication and you will find out that the official term is "Neisseria gonorrhoeae." "Gonococcus" is a colloquial term that has no place in an official publication and definitely should not be italicized. I do humbly recognize the omnipotence and infallibility of the state agencies, and I apologize for taking your time for nothing, because I realize that this letter will change nothing. Still, I refuse to stand by idly when the language and the terminology are raped with silent acquiescence of the editor of a presumably scientific journal.

Thank you very much.

Steve Z. Lintymer, M.D.
Pathologist
Columbus

P.S.: I presume we agree on the basic premise that language in general and scientific terms in particular should be used with precision to avoid confusion.

Dear Dr. Lintymer:

I would like to respond to your comments to the editor of the *Journal of the Medical Association of Georgia* concerning an italicized term, "Neisseria gonococcus," in their article, Incidental Intelligence. The Rules of the Department of Human Resources were cited.

It would appear that the error originated with the use of Stedman's *Medical Dictionary* (23rd Edition, 1979) under the heading of Neisseria: "N. gonorrhoeae, gonococcus; Neisser's coccus; a species which causes gonorrhoeae and other infections in man. . . ." The term "gonococcus" may be colloquial, but it is the commonly used descriptive term in most basic bacteriology texts, and not the proper name.

In the Rules of the Department of Human Resources (Chapter 290-5-20, Prophylactic Treatment of the Eyes of the Newborn), the term is not italicized. The italicization appeared de novo in the April, 1983, issue of the *Journal of the Medical Association of Georgia.*

You are to be commended for your keen observation and editorial precision. Thank you for bringing this to our attention.

Sincerely,
James W. Alley, M.D., M.P.H.
Director
Division of Public Health
Atlanta

One Member's Opinion on MAG's Deficit Budget

Dear Sir:

I would like to share with you and the membership some of the experience that our Reference Committee F had with the budget of our organization. As most of you know, our total of income and expenditures is well over a million dollars.

We have an active organization involved in many important medical related activities. When we sat down to re-evaluate our budget, we found that everybody wanted the "same" dues but "increased" activity. Everybody wanted more "bang out of a buck," and to make it stretch further than they stretch their own. If we are to act like a State Organization with influence and public responsibility and maintain our image within our state, then we must pay for it.

The AMA jumped in early (2 years ago) and got their dues increased, some local societies have increased their dues, and next year MAG will be faced with another crisis in finance. We will *probably need a dues increase* just to break even. This year we project in having about a $75,000 deficit.

I do not think that the AMA has dealt with us fairly. They have established a "cracker jack" bureaucracy in Chicago that really does a good "image" job, *but* they do not give the states any benefits that would reduce our state operating costs. Everybody wants to make money in their own computer. The AMA does not provide enough service to the States. There is double bookkeeping, there is double education projects, double lobbying costs, and double types of similar personnel. I have "lobbyed" some of our AMA delegates on this point, but I don't carry enough weight to influence or effect any changes.

I would like to close in thanking Dr. Jack Menendez, our excellent Speaker of the House for allowing me to serve on Reference Committee F. His leadership is just what the doctor ordered.

Yours truly,
Marvyn D. Cohen, M.D.
Columbus
May 24, 1983

Poet Laureate Responds in Prose

Dear Evelyn [Ward Gay]:

I have had many compliments on your fine article on the Georgia Poet Laureate appearing in the current [May, 1983] issue of the *Journal of the Medical Association of Georgia.* I want to thank you again for your very nice interview and article, and I am delighted with it as you know.

Sincerely,
John R. Lewis, Jr., M.D.
Atlanta
May 23, 1983

Incidental Intelligence . . .

Nationwide Hotline Expands Search for Organ Donors

The nation's first toll-free telephone number for physicians, nurses and other health professionals with questions about a potential organ donor has been based at the University of Pittsburgh in Philadelphia. The number will assist health professionals by providing urgently needed information for a donor and referring the caller to their local procurement organization.

The number, restricted to doctors, nurses, and other health professionals, is 800-24-DONOR. The number operates 24 hours a day, 365 days a year. It is a service of the North American Transplant Coordinators Organization's (NATCO) and a part of their attempts to expand efforts to match available organs with those people waiting for a transplant. NATCO is the professional association of individuals responsible for organ procurement in hospitals.

According to Donald W. Denny, director of organ procurement for the University of Pittsburgh, there are 110 organ procurement centers in this country, but often doctors and health professionals don't know who to contact locally when a donor is identified. The new number provides information on the organ needs of the major transplant institutions in this country and Canada. It includes information on kidneys, hearts, livers, lungs, pancreases, and heart/lungs.

Congress Acts Swiftly on Health Insurance for the Unemployed

Proposals to aid 11 million Americans who lost their health insurance when they or a family member lost their jobs passed a major congressional milepost in late May as the House Commerce Committee endorsed a plan that will cost about $2.6 billion in 1984.

Despite the objections of the Reagan Administration and the nation's governors, the Commerce Committee approved the measure by a convincing 34 to 8 vote. Crafted by Rep. Henry Waxman (D-CA) and Rep. Edward Madigan (R-IL), the plan is a compromise that would terminate after three years. It would base federal funding on the level of unemployment in the state. It would require employers to provide laid-off workers health coverage for 90 days and to permit open enrollment of workers or dependents previously covered under a laid-off spouse's plan.

States would be required to cover at least 9 days of hospital care and ten physician visits and to charge the worker a premium of at least 2% of his unemployment benefits. The state could employ a variety of administrative mechanisms, including Medicaid, insurers or providers.

Kidney Dialysis Rules Reissued — Opponents Still Find Fault

In February of 1982, the federal government proposed new rules for paying kidney dialysis facilities and physicians. More than a year and 4,000 comments later, the final rules have been issued in much the same form as they were originally proposed.

The rules, published in the May 11 *Federal Register*, are intended to implement an incentive payment system that Congress first proposed in 1978 and that was to have gone into effect in July of 1979. The new rules, which would take effect August 1, 1983, appear to do little to abate the criticisms made of the earlier proposal, only slightly modified in the final rules.

Under the new rules, both physicians and facilities will receive the same amount for treating patients dialyzing in the facility as for those dialyzing at home. Hospital-based dialysis facilities will be reimbursed at slightly higher levels. Payment rates will vary according to regional wage indexes. Physicians and facilities will continue to receive 80% of the allowable payment from Medicare and 20% from the patient. An exception which has permitted 100% Medicare reimbursement of the cost of home dialysis equipment has been eliminated.

The regulations are so little changed from the original proposed regs that most of the groups that criticized them in the first place say they are far from satisfied with the final product. Both the National Association of Patients on Hemodialysis and Transplant and the Renal Physicians Association are considering lawsuits to prevent implementation of the new rules and several congressional committees say they are still not satisfied with the regulations which resulted in three congressional hearings when they were first proposed.

Complaints include fears that the facilities will be forced to cut staff to keep costs below the payment levels, concerns that facilities will encourage home dialysis for patients who are good candidates for transplants, the belief that the data used to develop the rates is old and inadequate, and charges that the payments for hospitals are inadequate and so similar to those for independent facilities that the regulations in effect flaunt the law's mandate for a two-rate structure.

Measles Outbreak in Georgia

Although measles appears to be almost eradicated in Georgia and in the United States, two age groups are probably harboring enough unprotected persons to permit significant spread of this by-no-means benign disease when cases are imported from other parts of the world or other states. The groups public health officials remain concerned about are preschool and college age students.

Outbreaks of measles among college students in Indiana, Texas, and Michigan have received national attention recently. There was concern that students' travel to recreational areas during spring break might further spread the disease on campuses around the country. Since there is an incubation period of about 14 days from exposure to measles until appearance of the characteristic rash, the time for concern has not yet ended.

Why are there susceptible persons in the college ranks? Persons born after 1956 but old enough to have missed out on recent campaigns to ensure immunization of high school and younger students may have missed out, also, on both exposure to natural infection and measles vaccination. Some of those who were immunized during the early years of the vaccine — 1963 to 1971 — may not have benefitted because of being immunized too young or because of technical pitfalls with the administration of the different vaccines available at first. The general rule for college students is: make sure you receive live virus measles vaccine after the age of 1 year and after 1967. Even if the Indiana scare is over for now, it could happen again here or elsewhere. The general rule still stands: BE PROPERLY IMMUNIZED.

It is more complicated for the small children. They have to depend on parents, doctors, and health departments to do what is right for them. Too often a lot of other priorities get in the way of early and appropriate measles, mumps, and rubella immunization.

Largely because almost all children in day care, head start, and grades kindergarten through 12 have been protected and have the papers to prove it, Georgia had zero cases of measles from September, 1981 until January, 1983. Now we know about six cases.

One was in a 12 year old who had been properly immunized. This was one of the rare instances when the vaccine just did not work. We do not know the source of this patient's infection.

One 2 year old missed his scheduled shot because he was sick at the time.

One child was under a year old — too young for routine measles immunization. He shared it with three friends who were old enough but had not been immunized.

We need nearly 100% immunization levels in preschoolers to be protected against measles outbreaks. All of us, parents, physicians, and public health officials, need to care more and try harder to reach this goal.

(Submitted by James W. Alley, M.D., M.P.H., Director, Division of Public Health, Georgia Department of Human Resources.)

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MEDICAL MEETING CALENDAR

JULY

18-21 — *Hilton Head, SC:* **Clinical Cardiology.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

19-23 — *Hilton Head, SC:* **Sixth Annual Symposium on Contemporary Clinical Neurology.** Contact Mrs. Joan Sullivan, Dept. of Neurology, Vanderbilt Univ. Sch. of Med., Nashville, TN 37212. PH:615/322-3461.

22-23 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

25-27 — *Kiawah Island, SC:* **Pediatric Update 1983.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

28-31 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 credit and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

1-5 — *Hilton Head, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

8-12 — *Atlanta:* **Internal Medicine Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

24-28 — *Hilton Head, SC:* **Summer Imaging.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

25-28 — *Savannah:* **Georgia Psychiatric Association Annual Meeting.** Category 1 credit. Contact Samuel Brown, MD, Chairman, Comm. on CME, Ga. Psy. Assn., 3280 Howell Mill Rd., Ste. 212, NW Med., Ctr., Atlanta 30327. PH:404/351-2330.

27-28 — *Callaway Gardens:* **Medical Malpractice and the Anesthesiologist.** Category 1 credit. Contact William Hammonds, MD, Secy-Treas., Ga. Socy. of Anesthesiologists, Emory Univ. Hosp., Dept. of Anesth., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

SEPTEMBER

1-4 — *Sea Island:* **Tri-State Otolaryngology Assembly.** Category 1 credit. Contact Warren Griffin, MD, Program Chairman, 800 First St., Macon 31201. PH:912/743-8953.

11-14 — *Sea Island:* **Annual Meeting — Georgia Urological Association.** Contact Richard C. Estes, MD, Secy-Treas., 35 Collier Rd., NW, Atlanta 30309. PH:404/355-0813.

12-14 — *Atlanta:* **Echocardiography.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16 — *Savannah:* **Neonatology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-17 — *Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Secy-Treas., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

26-29 — *Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

6-8 — *Hilton Head, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

7-8 — *Atlanta:* **Gynecologic Oncology Update: 1983** (co-sponsored by the Georgia Chapter, American Cancer Society). Category 1 and AAFP prescribed credits. Contact Arnold Bernstein, MD, Prog. Chmn., Georgia Baptist Med. Ctr., 340 Boulevard, NE, Atlanta 30312. PH:404/577-1555.

8-12 — *Atlanta:* **American Society of Anesthesiologists.** Contact ASA, 515 Bussee Hwy., Park Ridge, IL 60068. PH:312/825-5586.

10-13 — *Atlanta:* **ACC Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-21 — *Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

19-22 — *Hilton Head, SC:* **Fifth Annual Hilton Head Symposium on the Clinical Management of Diabetes and Endocrine Disorders.** Category 1 and AAFP prescribed credits. Contact Edwin Bransome, Jr., MD, Dept. of Med., MCG, Augusta 30912. PH:404/828-3445.

22-27 — *Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P.O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

NOVEMBER

9-13 — *Atlanta:* **Georgia Academy of Family Physicians Annual Scientific Assembly.** Category 1 and AAFP prescribed credit. Contact GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

11-12 — *Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

17-20 — *Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester Lane, Exec. Secy., 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

18-20 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

30-Dec. 4 — *Atlanta:* **Eighth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

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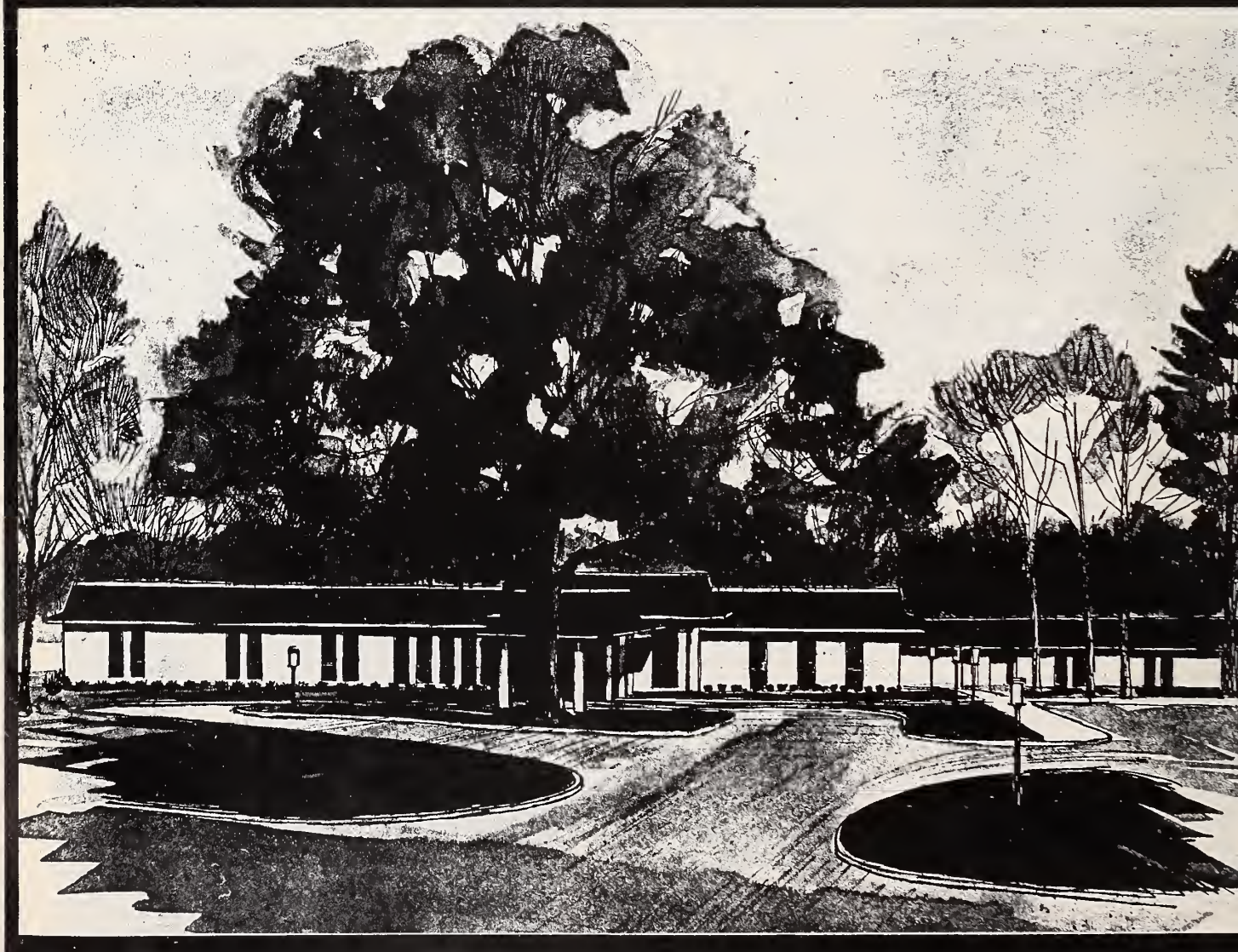
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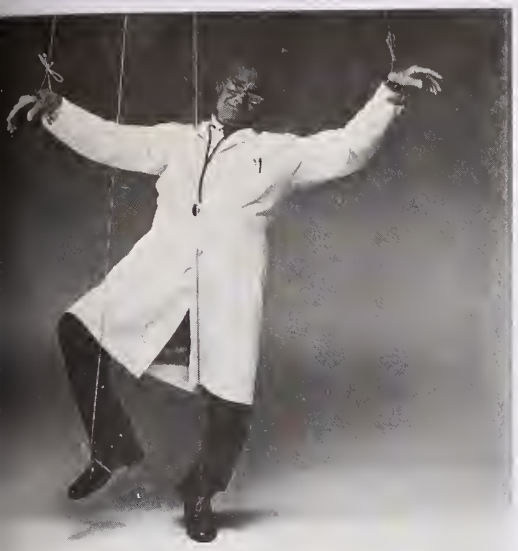
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JOURNAL
of the medical association of
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Operation Care

WILLIAM D. LOGAN, JR., M.D., and KEN WILLIAMS, *Atlanta**

"IT TOOK A HEART ATTACK for John Smith (the name of the patient and the hospital have been changed to protect patient confidentiality) to admit to himself he was sick. For 30 days, the unemployed trucking executive suffered chest pains but would not go to the doctor because he had no insurance. He was saved by a program that offers free medical care to those who have recently lost their insurance. . . ."

These are the words of Wyatt Andrews reporting on Operation Care for the CBS Evening News With Dan Rather. The report aired May 9, 1983 — exactly 1 week after Operation Care began taking calls from the public.

The CBS story continued, ". . . John Smith is just one number of a class of patients that doctors call the medically poor. They are patients who may own cars and even homes but also are victims of the recession and who lost medical benefits when they lost their jobs. Government estimates say this class of little-income Americans could number 30 million, many of them too proud to go to the doctor without money. . . ."

John Smith is only one of hundreds of Georgians who is receiving medical attention through the physician volunteers participating in Operation Care. His story is dramatic but no less so than many others who have been helped over the last few weeks through the program initiated by the Medical Association of Georgia.

The following narrative of Smith's dramatic story is presented below as it appeared in a page one article of *The Atlanta Journal* on May 5:

> "Monday, the day that the new program called Operation Care, went into effect, Smith was having chest pains. His wife, desperate to get him help and realizing he might qualify for the new program, phoned the number — 874-2273 — listed for the program.
>
> Volunteers manning Operation Care's telephone lines checked their computer listings of doctors who had volunteered to provide the medical care at no cost. Smith was referred to Dr. Russell Kramer. . . .
>
> "It sounded like he needed help right away, and I told him to come into my office as soon as possible," said Kramer Wednesday. Smith was given an electrocardiogram shortly after he arrived at Kramer's office.
>
> The EKG showed that Smith was having a heart attack.
>
> He was quickly sent to a local hospital and admitted to the intensive coronary care unit. There, he was placed under the care of Dr. Stuart J. Toporoff."

The hospital reports that Mr. Smith was discharged on May 31, almost 1 month from the day of his admission. Although Mr. Smith's bill is in the tens of thousands of dollars, his care (both the hospital bill and the physician's fees) will cost him nothing.

Background of Operation Care

Some brief history of how Operation Care began is in order. MAG's Executive Committee on March 13 endorsed a program to provide free medical care to those unemployed who, because of their unemployment, had lost their health care benefits. The program was designated Operation Care. On April 21, MAG's Board of Directors was presented the specific plans for making Operation Care a reality.

* Dr. Logan, a thoracic surgeon, is a member of the Board of Directors of Operation Care, Inc., and Secretary of the Medical Association of Georgia. Mr. Williams is Director of Public and Professional Relations for the MAG. Send reprint requests to Mr. Williams at 938 Peachtree St., NE, Atlanta, GA 30309.

A nonprofit corporation was subsequently established to raise funds for this free medical care program and is known as Operation Care, Inc. It has its own board of directors and officers, separate and distinct from MAG.

On April 29, a news conference was held and chaired by MAG's president, William W. Moore, Jr., M.D., an Atlanta neurosurgeon. The news media was presented the outline of the program. Their response was enthusiastic.

The basic qualifications for patients participating in the program are fourfold: 1) they must be unemployed some time *after* January 1, 1981; 2) they must not currently have health insurance; 3) they must be a resident of metro Atlanta (one of 11 counties); and 4) they must not be covered by programs such as Medicare, Medicaid, or similar government programs.

On May 2, Operation Care was started with 403 physicians in the metro Atlanta area, covering virtually all specialties. That first day, 51 referrals were made to physicians participating in the program.

To date, over 550 physicians have been signed up in the Atlanta area, and approximately 375 patients have been referred by Operation Care. A great many other callers have been referred elsewhere, such as to their own physician, to Grady Hospital, to one of the county health departments, or to other agencies if they do not qualify for our program.

Operation Care represents physicians at their finest — the consummate in compassionate, caring healers of the art of medicine.

The media has widely publicized our phone number (874-CARE). The patient calls the number and is screened by Auxiliary volunteers. *If* the patient qualifies, he or she is referred to a physician according to specialty required and geographic location. He or she is then given a referral number and told to show evidence of unemployment when he or she visits the physician's office.

We believe the program is meeting the needs for which it was designed. Naturally, there have been some problems. For example, we are still trying to obtain the cooperation of more hospitals, laboratories, and pharmacies to get them to donate their services all or in part. There has been minimal abuse by the public as far as we can discern.

Letters have been sent to all major businesses around the metro Atlanta area. So far, we have raised $1,035. The MAG Mutual Insurance Company is the major contributor to date. The only real cost to the program at this point is the monthly phone bill ($150-200) and occasional mailings. MAG is donating the office space. The Auxiliary is staffing the phones.



Mrs. R. Peevy (Nancy) Grant (left) interviews a caller to see if she qualifies for the services of Operation Care. Mrs. George R. (Judy) Jones, President of the Auxiliary of the MAG, reviews an application for medical care from an unemployed executive. Both are volunteers from the DeKalb Auxiliary. Photo by Elizabeth Best, DeKalb Neighbor.

Statewide Expansion of Operation Care

The Georgia Department of Labor says there are over 190,000 Georgians out of work, or roughly 7.2% of our work force. Nationally, the unemployment rate is hovering at the 10% level. Although we are not nearly as "economically distressed" as the nation as a whole, thousands of Georgians face an uncertain future — both in their jobs and with their health.

For this reason, Operation Care is spreading across the state. The Muscogee County Medical Society began Operation Care — Columbus on May 9. Almost half of their physicians are participating. Overall, they are pleased with its effectiveness. though they are not receiving nearly as many calls as they can handle. Hospitals there are delaying charging the Operation Care patients.

In Savannah, the Georgia Medical Society held a news conference on Monday, June 6, and began the program the next day. They have already signed up over 90 physicians, with two of the three hospitals also participating.

Other county societies have expressed an interest — Bibb County (Macon), Crawford Long (Athens), Dougherty (Albany), and others.

Press Coverage

The purpose of Operation Care has been to provide needed medical care to those who, because they are temporarily unemployed and without health care benefits, cannot afford it. We have no doubt been aided in our efforts by the enthusiastic support of the news media.



Mrs. Charles W. (Grace) Walden, an Auxiliary volunteer from DeKalb County, checks the computer to locate a physician who has previously agreed to participate in Operation Care. Another volunteer has screened a patient calling in who needs an internist in Cobb County. The Auxiliary to the MAG has been the backbone of the program.

Photo by Elizabeth Best, DeKalb Neighbor.

Operation Care and the MAG have been featured on the Cable News Network, the American Medical Radio News, in the *New York Times,* and other papers around the state and nation.

The program has apparently influenced in a positive way the attitude among newspaper editors and television and radio station managers as evidenced by the coverage the program has received both statewide and nationally. One such editorial was presented by vice president and general manager of WAGA-TV in Atlanta. He talks about the criticism the medical profession has endured for years, and he also talks about the need to end such criticism:

> ". . . The medical profession has been criticized plenty in recent years. People say they don't care. All they are interested in is money. But a group of Georgia doctors is putting an end to that criticism in the most effective way. Over 400 Georgia physicians have volunteered to take care of the health needs of unemployed Georgians by participating in Operation Care sponsored by the Medical Association of Georgia. Operation Care is for the long-term unemployed, people who have been jobless since the end of 1980. These are the people who have fallen between the cracks, not eligible for any government programs and unable to afford private care. Operation Care is a tremendous service. We'd like to see the medical community make it a permanent project."

Other editorials appearing in *The Atlanta Constitution* have reflected similar positive attitudes about this latest effort by Georgia physicians to serve their communities. Similar articles have appeared in Columbus' *The Sunday Ledger-Enquirer, The Waycross Journal Herald,* and others. As more and more county medical societies have been offering the services of Operation Care, so has favorable media attention been focused on physicians and organized medicine.

The Future of Operation Care

One question which is often asked is how long will Operation Care continue? Before answering, we should be reminded that as physicians, our caring medically for those who cannot pay is not new. We have done this since doctors began practicing in Georgia in the 1700s and will no doubt continue to do so.

Operation Care, as an organized physician referral network to take care of the unemployed, will probably go out of business within the next few months for two reasons. The first is that Congress is considering a number of bills that would provide for the medical needs of the unemployed. For example, on May 24, the House Commerce Committee, by a 34-8 majority, endorsed a health insurance plan for the unemployed that would cost about $2.6 billion in fiscal 1984. The Senate is also considering its own legislative remedy. Senator Robert Dole's (R-Kan.) $1.8 billion 2-year block grant plan is seen as the major contender there. The House and Senate will confer on the differences and will probably do so in early June.

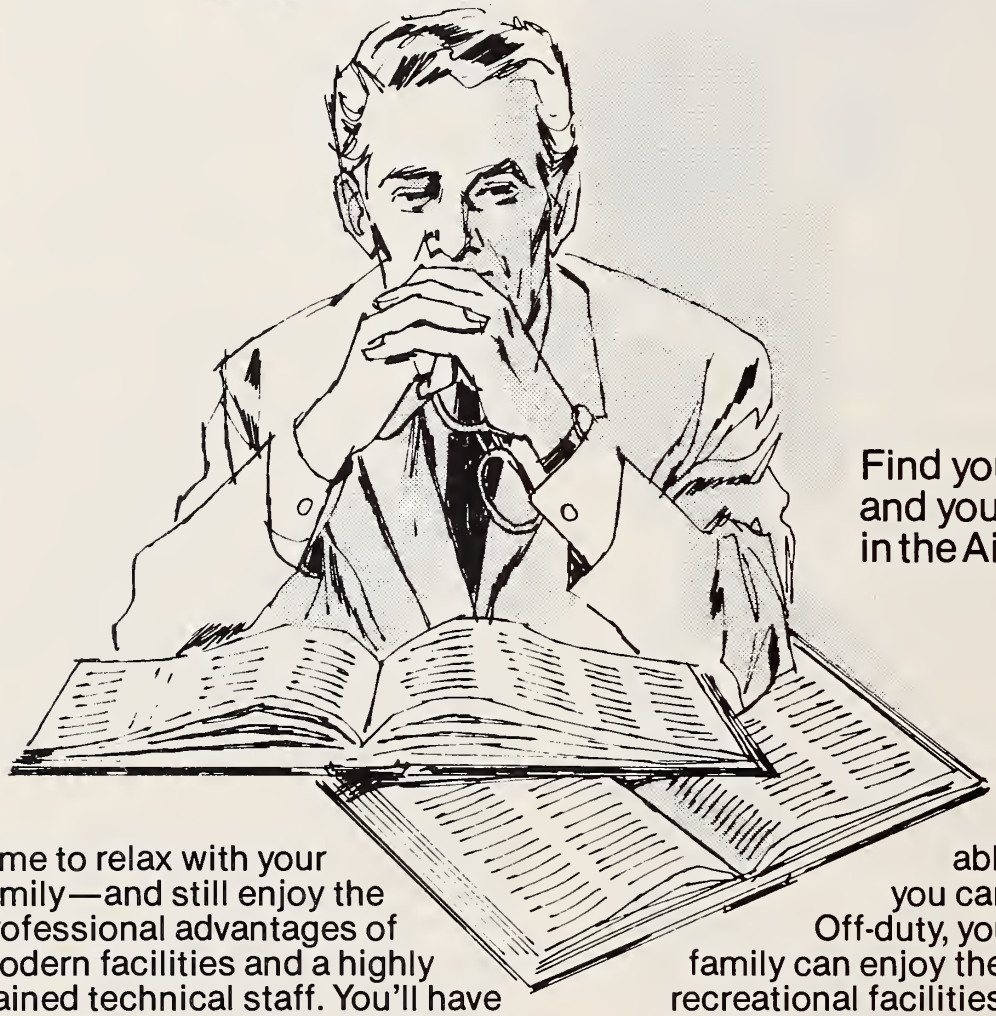
The other reason that may terminate the need for Operation Care is an improving economy. The Georgia Department of Labor tells us that from March to April, Georgia's unemployment dropped almost a full percentage point — down from 8.1% to 7.2%. The April figures are the latest available but it appears that most of the economic forecasters are correct and that the economy is on the upswing.

The Medical Association of Georgia is indebted to the hundreds of physicians who have donated their time to treat those in need of medical care without charge. We are further indebted to the Auxilians who have screened calls to insure that those most in need are provided the physicians' service.

The MAG strongly encourages all county medical societies to consider what will best work in their areas in developing similar programs of Operation Care. For additional details in how your society may begin such a program, contact Mr. Ken Williams at MAG Headquarters.

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AIR FORCE

A majority of those attending the seminars learned much and changed their practices in discernable ways to prevent potential malpractice situations.

Risk Management Workshops in Georgia — An Assessment of Their Impact

STEPHEN L. WILSON, PH.D., *Atlanta**

Introduction

FEW PHYSICIANS would argue that the threat of a malpractice suit does not affect them or the way they practice medicine. Malpractice suits, which in the not-too-distant past were rare, now occur with disquieting frequency, with some resulting in large awards for the plaintiffs who win. Recently, a $4.7 million medical malpractice verdict was awarded, the highest in Georgia's history. This trend has been of major concern to the Medical Association of Georgia (MAG) for several years. An attempt to deal with this crisis culminated in J. Rhodes Haverty, M.D., Chairman of MAG's *Ad Hoc* Committee on Risk Management, recommending the development of a series of seminars that would educate physicians in Georgia about the malpractice situation. In cooperation with St. Paul Insurance Companies, a workshop was designed that identified three major areas of concern for physicians: (1) potential areas of malpractice and how to avoid them; (2) physician responsibility when a suit is filed; and (3) what physicians should expect if a case should come to trial.

The Risk Management Seminars were designed to be presented in approximately 2 days to varying size groups of physicians. The seminars provided a format that included both lectures and small group sessions to maximize interaction and learning. The curriculum was designed to allow local medical societies to present the workshop to their constituencies. The educational experiences included discussion of patient cases, lectures on avoiding malpractice, physician-patient communication, medical records, and a simulated courtroom situation.

By most standards, the seminars have been successful. General feedback from the physician participants was favorable. Clearly, the issue of malpractice was of concern to the physicians, and most regarded it as a valuable learning experience. However, this perception may have been deceiving, and the overall impact may not have been substantial. One of the evaluative goals of the project was to conduct a follow-up evaluation at least 3 months after the participants returned to practice to determine the impact of the seminars. This article presents a brief description of that evaluation.

Evaluation Methodology

To evaluate the effectiveness of the malpractice seminars, a questionnaire was developed and administered to all of the physicians (1,300) who attended one of the 18 Risk Management Seminars held around Georgia between June 1980 and July 1982. A total of 313 (24%) of the participants responded with usable questionnaires. This was considered an adequate response to analyze the data; however, it does show a potential limitation of the study. It was quite possible that only those physicians who were the most enthusiastic about the seminars were the primary respondents and, thus, the data may have been skewed to reflect the perceptions of the minority of the population.

The questionnaire was constructed to obtain perceptions of the effectiveness of the seminars by having physicians respond in two different ways.

* Dr. Wilson is Associate Dean, College of Health Sciences, Georgia State University, University Plaza, Atlanta, GA 30303. Send reprint requests to him.

The first part of the questionnaire was composed of seven general statements that asked physicians to rate to what extent the seminars were helpful (or not helpful) in making them more knowledgeable about medical malpractice.

The second part included two open-ended questions requiring written, unstructured responses from the physicians. The first question asked respondents if the seminars caused them to change the way they conducted their practice and dealt with patients. The second question asked physicians to respond if they had been confronted with a potential malpractice situation that was handled differently because of attendance at the seminar. There were no other directions, and answers were completely at the discretion of the respondents. It was felt that if physicians took the time to respond to these questions, it would be a helpful indicator of the extent to which the seminars had been successful.

There was a third part of the evaluation questionnaire in which respondents were asked to critique the seminars. These data will be used in future planning but will not be described in this article.

Results

As seen in Table 1, the respondents reported a high degree of satisfaction with the material covered in the Risk Management Seminar and felt it made them more knowledgeable about malpractice. For each of the seven statements, over 80% of the respondents felt that they were either much more knowledgeable or somewhat more knowledgeable about malpractice as a result of the seminars. Overall, the data indicated that the majority of respondents felt the seminars made them more knowledgeable about malpractice and the effect on medical practice (87%), situations that can lead to malpractice (88%), how to avoid malpractice situations (91%), and how to keep comprehensive medical records (82%).

The respondents strongly agreed that the seminars had helped them work through the legal maze that could result in a malpractice suit. Eighty-two percent of the respondents felt that the seminars made them more knowledgeable of the legal procedure that would be followed if a claim were filed, 89% of the respondents felt that they knew what to expect from a defense or plaintiff's attorney, and 90% felt that they knew what to expect in a trial for malpractice.

The second part of the evaluation that asked physicians to identify how they had changed their practice or dealt with their patients as a result of the workshop brought some interesting responses. A total of 190 participants made various responses to the open-ended question, but 175 participants made responses that specifically showed how they had substantially changed their practices. From these responses, a total of 216 specific changes were identified for the analysis and placed into 12 broad categories (Table 2). The largest percentage of responses (44%) indicated that physicians clearly felt that since the seminar they were keeping better, more comprehensive medical records. The statements identified efforts at more documentation of hospital charts and office records. A few respondents also noted that

TABLE 1 — Physician Perceptions of Malpractice Seminars
Number (n) = 313

	Know Much More Since the Workshop (n) % of Total	*Know Somewhat More Since the Workshop* (n) % of Total	*Don't Know Any More Since the Workshop* (n) % of Total	*Knew It Before the Workshop* (n) % of total	*Total*
1. I know about professional malpractice and how it affects my practice.	(112) 36%	(161) 51.8%	(13) 4.2%	(25) 8%	311
2. I know the kinds of situations that can lead to malpractice.	(113) 36%	(161) 52%	(14) 5%	(23) 7%	311
3. I know how to avoid these situations and protect myself from malpractice.	(100) 32%	(183) 59%	(15) 5%	(11) 4%	309
4. I know how to keep good, comprehensive medical records that could hold up in a malpractice suit.	(117) 38%	(135) 44%	(22) 7%	(32) 11%	306
5. I know the kinds of legal procedures and insurance company procedures that will be followed if a claim is filed against me.	(132) 42%	(133) 43%	(30) 10%	(17) 5%	312
6. I know how the defense and plaintiff's attorney will handle my case if a malpractice suit is filed.	(133) 43%	(144) 46%	(18) 6%	(15) 5%	310
7. I know what could be expected of me if I had to go through a malpractice trial.	(124) 40%	(154) 49%	(18) 6%	(17) 5%	313

they had emphasized better documentation to their nursing and office staffs. Thirty-one percent of the responses indicated that physicians were concentrating efforts on better physician-patient relationships. Statements focused on the need to communicate better with patients, to listen carefully to them, and to spend more time with them to insure their satisfaction. Several respondents (11%) noted that the seminar made them more aware of potential malpractice situations. While this was a broad category, a number of physicians emphasized that they became more alert to the potential of malpractice and more cautious in the way they conducted their practices. This note of caution was expressed by many physicians and was a significant trend throughout many of the responses. A surprising percentage of respondents (8%) emphasized that they were documenting phone conversations much better, including any prescriptions or advice given to patients. This was an important point that had been emphasized many times at the seminars.

Some respondents cited other changes that included better explanations of procedures, changing informed consent procedures, and practicing medicine more defensively.

The second question asked physicians if they had been confronted with a potential malpractice situation and if so, how they had handled it. Twenty persons responded. The diversity of responses made categorization difficult; however, two broad categories were identified. First, there were 12 responses in which the physicians found themselves interacting with patients in a potential malpractice situation. As a result of the seminars, they indicated that they were more cautious, used consultation to back up opinions, fully documented any records, and made efforts to communicate completely with patients. Also noted were billing procedure changes to lessen potential legal problems such as not billing a dissatisfied patient, not going to small claims court for an unpaid bill, and waiting for 2 years before sending an unpaid bill for an adult patient to a collection agency.

In the second category, there were eight responses by physicians who found themselves in a position of dealing with plaintiff lawyers who represented a dissatisfied patient. Several noted that they declined meetings with lawyers, immediately informed their insurance company representatives, and obtained their own counsels and closely followed their advice.

TABLE 2 — How Physicians Changed Their Practice as a Result of the Seminars on Malpractice
Number (n) = 175

	(n)	% of Total
1. More comprehensive record keeping	(96)	44.4
2. Better physician-patient relationships	(31)	14.4
3. More cautious, alert to potential malpractice problems	(23)	10.6
4. Better documentation of phone calls	(17)	7.9
5. Better explanation of procedures	(16)	7.4
6. Better use of informed consent	(8)	3.7
7. Conduct medical practice more defensively	(8)	3.7
8. More use of second opinions, referrals, and consultations	(5)	2.3
9. Miscellaneous changes in practice (more careful exams of patients, use of chaperone in exam rooms, available on weekends)	(5)	2.3
10. Better communication of complications	(3)	1.4
11. Changed billings and collections procedures	(3)	1.4
12. Don't make guarantees to patients	(1)	.5
Total responses	216	100

Discussion

Perhaps the most striking finding was the overwhelming majority of the respondents who indicated satisfaction with the Risk Management Seminars. Several seminars were conducted by the MAG, while other seminars were conducted by local medical societies. While the curriculum was standard for all the seminars, the faculty and many times the mode of presentation were not always the same. Thus, there was the potential for varying levels of quality among the seminars which could create differences in levels of satisfaction among the participants. A few seminars were critiqued by physicians, but this evaluation study appears to indicate that, overall, the seminars were generally of high quality, and the respondents came away feeling that they were more knowledgeable about medical malpractice. This conclusion is most evident in the first part of the evaluation in which physicians were asked to rate several topics relating to medical malpractice covered in the seminars. The items covered the overall objectives of the seminars, and the data indicated that most of the physicians found the program very informative.

Perhaps even more interesting were the written responses to the open-ended questions. The effectiveness of any learning experience is best judged by whether or not it changes the behavior of the participants. Many educational programs are informative and enjoyable but do not necessarily change behavior. The open-ended questions were designed to determine if the seminars had caused a change in behavior. The fact that 175 of the 312 physicians returning the questionnaire took the time to write an answer appears to indicate that the workshop caused at least 56% of the responding physicians to change their medical practices in some way. The large number of responses indicating better record keeping and documentation of phone calls shows that many of the lessons learned through the seminars were practical.

While most physicians keep good medical records, they became more acutely aware of the importance of accurate and comprehensive documentation. As the seminars emphasized, many times the outcome of a malpractice case may depend on the written medical documentation, and poor records can work against a defendant physician.

The large number of responses emphasizing the need to establish and keep positive patient relationships appears to show an important outcome from the seminar. Most physicians understand the need for positive relationships with patients but many responded that this seminar reinforced the need for this in their practices.

The impact of the seminar may have also provided the opportunity to express some of the frustrations affecting physicians in practice. Many physicians reflected a significant concern for the malpractice crisis when they noted that they were now more alert and cautious in their interactions with patients. They also described some frustration at a legal system that forces them to maintain a more defensive medical practice.

The second open-ended question asked physicians to indicate if they had been confronted with a patient and a potential malpractice situation and how it was handled as a result of the seminars. On the basis of the responses received, it appears that physicians are able to deal with difficult patient situations. Furthermore, when placed in a potential legal situation, they acted correctly by informing their insurance company and following their advice. Overall, the data from the two open-ended questions seemed to indicate that the seminars made many physicians more proactive (rather than reactive) by critically looking at their medical practices and correcting potential problems.

Summary

This was a brief description of a study of the effectiveness of several seminars on malpractice that have been held throughout Georgia during the past 2 years. The analysis demonstrated that the seminars were quite successful according to a majority of physician respondents who answered the questionnaire. They clearly came away from the seminars knowing more about medical malpractice and more importantly, changed their practices in discernable ways to prevent potential malpractice situations.

Whether the current malpractice problems will decline in the future and whether a causal relationship can be shown with the seminars is not yet known. The data seem to indicate that the seminars are having an impact. Many physicians added comments that these should be offered on a continuing basis to keep them current on the malpractice situation. Additionally, other state medical associations have requested the curriculum and are planning their own risk management seminars.

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BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PRDCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PRDCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PRDCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PRDCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PRDCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PRDCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PRDCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PRDCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PRDCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PRDCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PRDCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PRDCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PRDCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PRDCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PRDCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PRDCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PRDCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PRDCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PRDCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PRDCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PRDCARDIA CAPSULE contains 10 mg of nifedipine. PRDCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these

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J-9043-4 July 1981



Atlanta's Academy of Medicine Is Rededicated to the Public

EVELYN WARD GAY, ***Decatur****

More than 300 members and guests of The Medical Association of Atlanta gathered at the Academy of Medicine on West Peachtree Street on Friday evening, April 29, to rededicate and tour the recently restored building.

Several visiting dignitaries were present for the program which preceded a buffet dinner served under tents set up on the front lawn.

Although the building is only 42 years old, it has been called one of Atlanta's best examples of neoclassic design, and its interior displays several items of historic interest. Built in 1941, and for many years the meeting place for Atlanta's physicians, it recently became necessary to release the space for outside use, and a complete overhaul was begun.

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.

History of the Medical Association of Atlanta

One of the oldest medical societies in the state, The Medical Association of Atlanta has a history which goes back to the early part of the 19th century. In 1854, when Atlanta was only 7 years old, the first organization of physicians in the young city was called "The Brotherhood of Physicians." Begun by Dr. John G. Westmoreland and his brother, Dr. Willis F. Westmoreland, who had been instrumental in founding Atlanta's first medical school, the group met under the original name for only 2 years before becoming The Atlanta Medical Society. The War Between the States brought an end to the new society, however, and all its records were lost. When it resumed operation in 1865, it was called The Atlanta Society of Medicine.

Six years later, in 1871, there appeared on the scene temporarily a similar organization known as



Several visiting dignitaries as well as local physicians and their spouses attended the rededication program which preceded a buffet dinner served under tents on the front lawn of the Academy.

The Fulton County Medical Society. In 1872, when Dr. Joseph P. Logan was president of The Atlanta Society of Medicine, the two groups merged and became The Atlanta Medical and Surgical Union, with Dr. Logan still at its head. Again, a year later, the name was changed to The Atlanta Academy of Medicine and Dr. Logan retained the presidency, making him successively the president of all three groups.

The Atlanta Academy of Medicine had only 50 members in 1879 when the society was host to a meeting of The American Medical Association. Sessions were held in Atlanta's newest theater, DeGive's Opera House. Only 15 years had passed since General Sherman and his forces had burned the city, but the visiting physicians were given a warm welcome.

For several years thereafter, the group moved about from place to place, meeting at various times in the State Capitol Building on the corner of Marietta and Forsyth Streets, in the YMCA building then located at Pryor and Auburn Avenue, or at the Knights of Pythias Hall in the Connolly Building at Whitehall and Alabama Streets. Rent could be had at these places for as little as $7, and dues for members were only $3 a year. However, those were hard times for physicians and very few could pay. At times, they were given free use of a room in the Equitable Building or a parlor in the Kimball House, a fashionable hotel.

In 1885, the organization's name was changed to The Atlanta Society of Medicine, and the next year The American Medical Association met again in Atlanta. Drs. E. C. Davis and L. C. Fischer soon offered the use of their office in the Flatiron Building at Peachtree and Broad Streets for meetings of the society, and by 1902, when the Carnegie Library opened, they were allowed to meet in the basement



Special guests at the rededication ceremony for the Academy of Medicine included, left to right: Dr. William Y. Rial, President of the American Medical Association; Dr. William W. Moore, Jr., President of the Medical Association of Georgia; Dr. M. Pinson Neal, Jr., of Richmond, Virginia, President of the Southern Medical Association; Dr. Harrison Rogers, Speaker of the AMA House of Delegates; Dr. Frank L. Wilson, Jr., President of the Atlanta Medical Heritage, Inc.; and Mr. Alexander Aldrich, a member of the President's Commission for Historic Preservation. Also present but not pictured were: Dr. Charles D. Hollis, Jr., of Albany, immediate past president of MAG, Dr. F. William Dowda, member of the Board of Trustees of the AMA, and Mr. Franklin M. Garrett, member of the Board of Trustees, Atlanta Historical Society, and author of *Atlanta and Environs*.

of that building. The organization adopted another name in 1905, The Fulton County Medical Society, and this time it stuck for more than 65 years. But it was 68 years from the time of the group's first organization before a temporary home of their own would be found by Atlanta's physicians.

In 1922, a frame house on Prescott Street was bought and the medical society moved into its new quarters in 1923. An auxiliary made up of physicians' wives was formed that year, the first in the state, and meals were prepared for the men in the kitchen of the house, under the supervision of Mrs. Floyd W. McRae, Sr., first president of the auxiliary. The main floor also had enough space for a meeting hall and a library, and the upstairs rooms were rented out as living quarters.

While the physicians were occupying their new home on Prescott Street, a new publication called *The Bulletin of The Fulton County Medical Society* was begun. But it was not long before the old house became inadequate for the society's needs. Discussions began to take place on the subject of a permanent, fireproof building to protect the group's valuable records.

In February, 1935, dues were raised to $22.50 for senior members and $15 for junior members, with $5 of each amount reserved for a building fund. Dr. Edgar D. Shanks, president, told the members that he hoped the people "would not measure the progress of medicine in Atlanta by their material progress." The old house, he said, was "decaying and sinking from age and weight" and was unsafe, since it would not stand another general repair job.

By 1937, when Dr. H. Cliff Sauls was president, he reported that $8,000 had been raised toward a new home. Nothing was done immediately, however, and in 1938 Dr. Carl C. Aven, president, declared that the need was urgent due to the fact that many members did not attend meetings of the society because of poor ventilation and uncomfortable seats in the old house.

In 1939, the property on Prescott Street was sold to the Crawford W. Long Memorial Hospital, located next door. A steering committee was named to select a site for a new building. After much searching, a lot measuring 200 by 400 feet was located on the corner of West Peachtree and Seventh Streets and the land was purchased for $18,000 from the Peters Land Company. Drs. Major Fowler and Jack Norris served as co-chairmen of the finance committee, and members contributed whatever they could afford to give.

The lot on which the Academy of Medicine was to be built had an interesting past. Formerly occupied by the Creek Indians, the land immediately surrounding the lot had been ceded to Georgia in 1821. In 1822, when DeKalb County was created, it fell into that county. In 1849, Richard Peters, a civil engineer from Pennsylvania, moved to Atlanta and bought the entire 202½ acres of land for $1,200. In 1853, it became a part of Fulton County when the area was divided again. After the War Between the States, the area became the location of several residences occupied by prominent Atlantans. Richard Peters married a daughter of Dr. Joseph Thompson, a retired physician, and built a Victorian mansion for her that fronted on Peachtree Street. One of the residents of the West Peachtree side of the lot was Dr. F. D. Thurman.

Atlanta had a population of close to 90,000 by the turn of the century when the property was taken into the city limits. In 1924, the Biltmore Hotel was constructed on the site where Dr. Thurman's house had stood, but the corner lot at Seventh Street was left vacant. It was this corner lot which was purchased in 1939 for the new Academy of Medicine. A contract was signed for the lowest bid of $115,561 on June 9, 1941. Ground was broken on June 10.

On Friday evening, October 17, 1941, a fund-raising dinner was held at the Biltmore Hotel. Seventy-six people gave $100 each and 50 of them enjoyed a $2 meal. Guest of honor was Margaret Mitchell, author of *Gone With The Wind,* who added her $100 contribution to the fund.

On December 15, 1941, dedication ceremonies were held for the almost-completed building. It was said to have been "not an occasion of unmixed celebration." Pearl Harbor still was fresh in the minds of the people, and the country had been at war for only 8 days. One hundred and fifty-three of the

society's members were then, or soon would be, in uniform. Three of those did not return — Dr. Guy A. Myers, Dr. George Eubanks, and Dr. Carl Garver.

A house committee made up of auxiliary members took on the job of selling the 298 seats for the Academy's auditorium. Several memorials commemorating Atlanta's medical heritage were placed in the building. The library was named for Dr. John G. Westmoreland, the original founder of the first medical society, and the chandelier in that room, a 165-year-old Waterford fixture brought from England in April of 1941, was placed in honor of Dr. Stewart Ralph Roberts, one of the first faculty members of The Atlanta School of Medicine. The 140-year-old antique chandelier bought to hang in the rotunda of the building came from the sets of the movie "Gone With The Wind," and was in memory of the late Dr. E. C. Davis, organizer of Base Hospital 43 in World War I, known as the Emory Unit.

This well-written historical review of the Academy and the Association for which it was built recalls the names and activities of many prominent Georgia physicians.

The 175-year-old Waterford crystal chandelier in the Auxiliary Room was brought from England in April of 1941 and was placed as a memorial to the wives of members.

The society moved into the new building in March of 1942. It was unfinished at the time, and all bills were not paid. War construction had prevented the contractor from completing the structure. The basement leaked with the first hard rain and had to be fixed. But the grounds were beautified by the generosity of Dr. and Mrs. F. Phinizy Calhoun and Dr. R. C. Adams. By the close of the war, the civilian members paid off the indebtedness on the building as a tribute to returning members of the Armed Services.

On July 7, 1942, members gathered in the new auditorium to honor one of their own, Dr. James Edgar Paullin, president-elect of The American Medical Association. On April 4, 1946, they gathered again at the Academy of Medicine to dedicate the auditorium of the building to the late Dr. Abner Wellborn Calhoun, a prominent ophthalmologist who had become a professor at The Atlanta Medical College and established the first eye clinic in the South. A portrait of Dr. Calhoun was unveiled in the auditorium on that April day in 1946 by his grandson, Dr. Abner Calhoun Witham.

In 1964, The Fulton County Medical Society sponsored a crash program called S.O.S. (Sabin Oral Sundays) to help protect a large segment of the population from poliomyelitis. After running for 6 Sundays, two and a quarter million doses of vaccine had been given out. Many civilian volunteers from all walks of life joined physicians to participate in the undertaking. Total donations, which had been collected in containers at the various vaccination centers, exceeded expenditures by $22,094.60, and the excess was turned over to the Artificial Kidney Center being organized at the Grady Memorial Hospital. Co-chairmen Drs. Albert A. Rayle and John T. Yauger received the Aven Citizenship Cup award given by the society that year for their achievement.

But only a short time later, the tremendous volunteer efforts of Atlanta physicians in the polio vaccination program would be forgotten by public officials. In 1965, a court ruling found that The Fulton County Medical Society "was not a scientific institution but rather a social one." The group's tax exempt status was no longer allowed, and a bill was received by the society in the amount of $80,000, the sum being retroactive for an 8-year period. A nonprofit organization with no reserve funds, the society found it necessary to levy a heavy assessment on its members and raise annual dues in order to pay the taxes on their property.

In the early 1970s, the name of the organization was changed to The Medical Association of Metropolitan Atlanta, Inc., and members of the society were considering selling the property. The auxiliary began looking into ways to prevent total loss of the building. Through their efforts, it was listed on Atlanta's official roster of Historic Sites, Structures, and Districts by the Atlanta Urban Design Commission. By 1979, when the society again was pressed to sell the property, the auxiliary spearheaded a concerted drive to save the building. It was led by Mrs. Perry M. White, 1968-1969 auxiliary president.

On April 30, 1980, the Academy was placed on the National Register of Historic Places. In the following months, with the help of many people, the drive continued to raise funds for a complete restoration. In February of 1981, the Academy of Medicine, now valued at approximately $800,000, was turned over by the society to a recently created nonprofit foundation called The Atlanta Medical Heritage, Inc., and plans for the restoration began. The society contributed $100,000 toward the fundraising campaign, and the auxiliary raised an amount totalling almost $90,000.

The newly-refurbished building will continue to be used as a meeting place for the physicians of Atlanta and their spouses, and will remain as headquarters for the group's activities, but it also will be made available as an attractive, convenient, and unique place for business and civic meetings and for cultural and social affairs of other organizations.

Both inspiring and realistic in his remarks, Dr. Sullivan highlights the past, present, and future goals that are his as the first president and dean of the Morehouse School of Medicine.

The Morehouse School of Medicine: A State of Mind, of Mission, and of Commitment

LOUIS W. SULLIVAN, M.D., *Atlanta**

MR. CHAIRMAN, Distinguished Dias Guests, Delegates from Educational Institutions, Learned Societies and Governmental Agencies, Students, Faculty and Staff in the Morehouse School of Medicine Family, Friends of the School of Medicine:

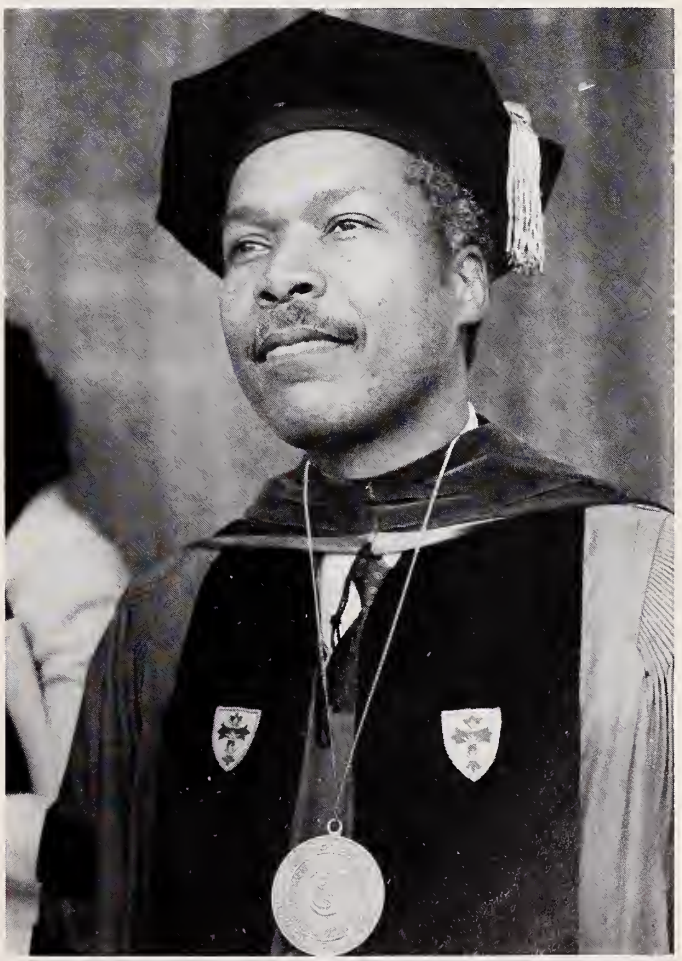
I am overwhelmed by your generosity and your support, and I am personally touched by your presence here today.

The theme of my administration has been, and continues to be "the Morehouse School of Medicine: A State of Mind of Mission and of Commitment."

The road we have chosen, in accepting the deanship and the presidency of this fledgling institution, is one of hard work, of great risks, of high tensions, of delayed gratifications, and of constantly changing variables — both inside and outside of the institution.

But it is also a road with tremendous opportunities for meaningful service, of lasting contributions to one's fellowman, and for service to higher education in the United States in this final quarter of the twentieth century.

The Morehouse School of Medicine has come into being during a time of great expansion of medical education in the United States — a period from 1956 to 1982, which spawned the development of 47 new medical schools so that now, one in every three U.S. medical schools is less than 25 years old; a time which witnessed an increase in our nation's annual production of physicians from 7,000 in 1956 to 17,000 in 1982.



Louis W. Sullivan, M.D., President and Dean, the Morehouse School of Medicine, following the investiture at his inauguration.

In the past 25 years, we have gone from an era of a

* Dr. Sullivan, founding dean of the Morehouse School of Medicine, was installed as its first president and dean on April 10, 1983. Printed here is his inaugural address. Send reprint requests to him at 720 Westview Dr., SW, Atlanta, GA 30310.

pending shortage of physicians to a presently projected surplus of physicians by 1990.

In 1968, and for many preceding decades, less than 2% of U.S. medical students were black, due to the legacy of slavery, segregation, and discrimination in our country. Up until the mid 1970s most of the black physicians in the United States were graduates of the two predominantly black medical schools which existed at that time — Howard University and Meharry Medical College, each more than 100 years old.

So, in 1969, the Morehouse School of Medicine was an idea whose time had come. Nurtured and sustained by Dr. Louis Brown, a black physician in Atlanta, and supported by his colleagues in the Georgia State Medical Association, this wild idea found a patch of fertile soil in 1973 at Morehouse College, some 10 years ago when its President, Hugh Gloster, and its trustees Thomas Kilgore, Calvin Brown, and others agreed to the development of the Morehouse School of Medicine.

During the past 10 years, the Morehouse School of Medicine has been helped by an ever-expanding circle of friends and supporters — including the Medical Association of Georgia, Emory University, the Medical College of Georgia, the U.S. Department of Health and Human Services, the U.S. Department of Education, the Governor of Georgia and the Georgia Legislature, the U.S. Congress, the Fulton County Commission, the Mayor and the City Council of Atlanta, foundations, corporations, and individuals. Many friends, though we still need many, many more.

Morehouse is the first minority medical school to be founded in the 20th century and is one of only four in the nation.

The Morehouse School of Medicine was founded with its major mission being the education and training of more physicians from minority and socioeconomically disadvantaged groups for work as primary care physicians for our medically underserved citizens in rural areas and inner cities. This mission continues today as our major thrust, for in 1983, black physicians still comprise less than 3% of all physicians in the United States.

However, as an educational institution we also recognize the need for more black faculty, black research scientists, and black administrators for our own institution and for others in the nation. To provide a strong educational environment for future primary care physicians, our institution needs an environment which encourages free inquiry, the testing of old ideas, and the discovery of new truths. Thus, we seek a balanced institution with a major



Monroe E. Trout, M.D., Vice-Chairman of the MSM Board of Trustees and Senior Vice President of Sterling Drug Company, NY, NY, congratulates Louis W. Sullivan, M.D., upon completion of the investiture of Dr. Sullivan as the school's first president. At left is board chairman, Clinton E. Warner, Atlanta surgeon.

thrust in training for primary care, but with supporting, diversified activities in health services research, biomedical research, and related activities.

Our institutional goal is to become a leader in developing sound innovations in medical education and the development of models for the efficient, effective delivery of health services for our medically underserved citizens.

The Morehouse School of Medicine has witnessed in recent years severe retrenchment in federal and other support for medical education, medical research, and support for medical care. We have been spawned during an era when many have questioned the need for, or the validity of, predominantly black higher education institutions. Those individuals perhaps do not recognize the critical shortage of black health care personnel in the United States. It is clear that they are not aware that a very high percentage of the private health care given to black Americans in 1983 is given by black physicians. They are probably totally unaware that projections by the U.S. Department of Health and Human Services show that, based upon current trends, there will be a continued critical shortage of black physicians to the year 2000 and beyond. So we need the contributions of all medical schools, minority and majority, to train the black physicians needed by our nation.

This is not to suggest that all health care for black Americans should be given by black physicians, nor should black physicians be limited to ministering only to black patients. For we truly believe in an integrated society. But blacks, like all ethnic groups in the United States, must be given the opportunity to make their contributions and to share in the responsibilities for our continuing development as a nation into the utopia to which we all still aspire.

We have shown at the Morehouse School of



James A. Kaufmann, M.D., Atlanta, Vice-Speaker of MAG's House of Delegates, congratulates Dr. and Mrs. Louis W. Sulivan following the official inauguration of Dr. Sullivan as the first president of the Morehouse School of Medicine. Behind Dr. Kaufmann are Cheryl Johnson, member of Dean Sullivan's staff, and her husband, William Johnson.

Medicine that true integration is a two-way street, for at Morehouse we are indeed a family of black, white, Hispanic, and Asian-American students and faculty, in an institution with a predominantly black heritage. This is as valid as is the existence of a Brandeis, a Notre Dame, a Loma Linda, or a Brigham Young, each of which has a particular cultural or religious or ethnic orientation, but a diverse student body, which is given a sound general education.

The Morehouse School of Medicine is contributing to the diversity and the pluralism among our medical schools in the United States — with rigor and commitment to high academic standards and high achievement by our students, our faculty, and all those in our institution.

We are committed to our students. We want to assure them of the best opportunities at Morehouse for self-discovery, personal and professional growth, and the development of habits and attitudes which will lead to life-long learning. We must *forever* be students, with personal integrity and taking no short cuts to learning, if we are to be competent physicians in the years to come and if we are to bring to our patients and to our communities the best which medical science has to offer for the promotion of health, for the treatment of disease, and for the relief of pain and suffering. We want our students to pursue the ever deepening mystery and wonder of life, of respect for the individual *and* for a Higher Being. Man is more than the sum of his parts. He is body *and* soul. We must always treat both with care, with deference, and with respect.

We are committed to our faculty. We must provide the basic facilities for them to work their magic — transmuting over a span of 4 years young college graduates into competent, eager physicians. We must work with them to develop a supportive educational environment for teaching and for learning. We must share with our students and faculty the purifying process which is provided by the crucible of research, by the exploration for new knowledge, which, in turn, constantly renews and refreshes the faculty. We must broaden and strengthen the base of collegiality for the growth and health of the institution.

We are committed to our staff. They are the gears and the lubricant which keep the institution functioning — who keep the lights burning, the grass cut, the bills paid, the supplies in stock, the papers typed, duplicated, and collated, the schedules made, conferences organized — all the while keeping a low profile and letting others take the credit. Without them, there would be no institution. We salute them.

We are committed to our trustees. We look to them for their leadership, their counsel, their influence and their affluence — which they are sharing with the Morehouse School of Medicine. They donate their time, their ideas, their work, and their wealth. We are committed to the efficient and effective use of all their gifts.

We are committed to the Atlanta University Center, a 54-year-old consortium of six educational institutions, which soon will be seven, when joined by the Morehouse School of Medicine later this year. Working with these four colleges — Morehouse, Spelman, Clark, Morris Brown — with the graduate school, Atlanta University and with the Interdenominational Theological Center, the medical school will benefit from, and will contribute to, the strength of the educational enterprise of this largest center for private predominantly black higher education in the world.

In 1983, black physicians comprise less than 3% of all physicians in the United States.

Working with the Center institutions, we envision the strengthening of many existing programs in the biologic and the social sciences, the humanities, the development of programs across disciplines, such as health economics, biomedical engineering, medical sociology, and many more. Working together, we can achieve much.

We are committed to our city and to our state, to keeping the public trust invested in us and in our institution — by training the kinds of health professionals needed by our state, by maintaining high standards of scholarship, of personal integrity and service, by providing counsel and assistance to our public officials as they grapple with the difficult problems of how to allocate their limited resources for the many services needed by our citizens.

We are committed to our nation, to maintaining the strength and the diversity of the nation's medical education community, to helping find new ways and to improving our old ways, for training tomorrow's health professionals, to finding methods for constraining spiralling health care costs without compromising the quality or availability of health services, to helping assure that our most talented and dedicated young people can still aspire to develop and to use those talents as physicians and other health professionals.

Our commitment extends to our educational colleagues around the globe. We aspire to doing our part, to making our contribution to the strengthening of educational programs and health delivery systems at home and abroad. In short, we are committed to working for the eradication of poverty, hunger, ignorance, and disease wherever they exist.

"Let the word go forth from this place, that the Morehouse School of Medicine will do its share to improve our world."

We also are committed to future generations of Morehouse medical students, faculty, administrators, and trustees; to building a firm foundation for others who will occupy these halls in the future, for their superstructures and their elaborations yet to come. Today we walk, that tomorrow they soar, like eagles through the sky.

Tall dreams, yes. Big aspirations, yes. But all within our reach, all in the realm of the possible.

For these dreams to come true, for the future of the Morehouse School of Medicine to be bright, strong, and meaningful, what we need is your support, for each of you to do your part to the fullest — for our students to aspire to be the best students they can be — bright, inquisitive, examining and challenging old ideas, and daring to propose new ones — for our alumni to aspire to be competent, compassionate physicians, who recognize their limitations but are forever working to push back the horizons of their knowledge — for our faculty to be committed to contributing their best ideas and their best efforts to building and maintaining a center of academic excellence and an environment conducive to teaching and learning — for our staff and administrators to find ways of doing things better with fewer resources — for our trustees to be committed to going that extra extra mile, and then some, to see that the financial stability and fiscal integrity of the institution becomes strong, so that the Morehouse School of Medicine can develop the endowment and facilities needed to withstand the present and future vicissitudes that befall educational institutions. We need the commitment of our many friends in government and in the private sector, to share our dreams, our goals, and our aspirations — to believe in us and our mission and to give us a helping hand.

In asking for your help, we also seek your advice, your criticism, and your evaluation of our institution, its people, and its programs. This contributes to our efforts to develop an institution of strength and relevance to the communities and the constituencies we are designed to serve.

With the commitment of our many friends — local, regional and national — and with the help and blessings of God, the Morehouse School of Medicine will succeed in its mission and will bring manifold benefits to our city, our state, our region, and our nation, as we serve you, and also prepare for the 21st century, less than 17 years away.

Let the word go forth from this place, that the Morehouse School of Medicine will do its share to improve our world.

That is *our* state of mind, our mission, and our commitment.

Osler's value system is as relevant to medical education today as it was at the turn of the last century.

Osler: A Role Model for Today's Physician

JOHN D. CANTWELL, M.D., *Atlanta**



Figure 1 — Sir William Osler, Chief of Medicine at the Johns Hopkins Medical School, 1889. (Photo courtesy William Osler Abbott)

While I was contemplating whether or not to accept a position as Acting Director of Internal Medicine at Georgia Baptist Medical Center, a physician friend gave me a copy of Cushing's two-volume biography of Sir William Osler.[1] I had always intended to read it, being an admirer of Osler's approach to medicine and to life, but heretofore had not had the opportunity to do so. I set about the task with some trepidation, as I would with any 1400 page book. I quickly became immersed in the man, his ideas, and his role as a teacher par excellence. I was impressed with the timelessness of his dictums and found him to be a perfect role model for the challenge I finally decided to accept.

Osler, the youngest son of an Anglican missionary living on the edge of the Canadian wilderness, was born in 1849. Expelled from public school (for apparently shouting abusive remarks through the keyhole of the headmaster's door), young William entered boarding school where he came under the influence of Rev. William Johnson, a minister and natural scientist. Osler pursued a similar interest in biology and also excelled as an athlete. He participated in all the school sports, winning a prize for kicking the football and once threw a cricket ball an estimated 115 yards, a record for an amateur. He also competed in the hurdles, dashes, and the steeplechase, until his athletic pursuits were curtailed by osteomyelitis.

At Trinity College in Toronto, Osler encountered Dr. James Bovell, a physician and biologist who was in the process of switching to the priesthood. Bovell opened his home to Osler, sharing his personal library of classical and medical books and was to become a lifelong influence on him. When he entered McGill Medical School, Osler met Dr. Palmer Howard, the third man (along with Johnson and Bovell) who influenced him so. Like Dr. Bovell, Howard also gave Osler ready access to his library, something that in years to come, Osler would do for his own students.

* Dr. Cantwell is Acting Director, Dept. of Internal Medicine, Georgia Baptist Medical Center, 300 Boulevard NE, Atlanta, GA 30312. Send reprint requests to him.

After graduation, Osler joined the staff at McGill as a pathologist, and remained there until 1884, when at age 35 he was summoned to a professorship in medicine at the University of Pennsylvania. Five years later he accepted the position as chief of medicine at the new Johns Hopkins Medical School (Figure 1). Within 3 years he had written a textbook of medicine (dedicated to Johnson, Bovell, and Howard), married the widow of a physician friend, and established a method of clinical teaching which still exists today. He remained at Hopkins for 16 years, finishing his career as the Regis Professor of Medicine at Oxford.

Osler's value system is as relevant to medical education today as it was at the turn of the last century. He believed in *punctuality,* stating that it is "the prime essential of a physician. If invariably on time, he will succeed even in the face of professional mediocrity." He advocated the importance of being *organized,* encouraging his students and housestaff to divide their lives into 24-hour compartments, focusing on each day's work. He believed in *scholarship* and the necessity for *daily study,* reminding us that "it is astonishing with how little reading a doctor can practice medicine, but it is not astonishing how badly he may do it." He encouraged the students to obtain a *well-rounded education,* insisting that they "rest not satisfied with . . . professional training, but try to get the education, if not of a scholar, at least of a gentleman." Osler thought that

"Some (physicians) continue to test their conduct in a dilemma by asking the question, what would Osler have done."

the young medical house officer should "seek knowledge for itself without a thought of the end, tested and taught day by day, the pupil and teacher working together on the same lines, only one a little ahead of the other." His home became "Open Arms" to the residents, who were given keys to his private study. Osler met with these "latchkey" students one evening each week, (seated around the dining room table (Figure 2), reviewing interesting medical topics and items of historical and cultural importance.

Osler taught clinical medicine for 45 years. A multitalented man, he could have excelled in many vocations. According to an editorial in a Baltimore



Figure 2 — The "latchkey table," around which Sir William Osler used to gather with medical students and housestaff. (Photo courtesy Mrs. Osler Abbott, whose dining room the table currently graces.)

newspaper, "Dr. Osler would have been great in any field — in the pulpit, in politics, in literature, in law — because God gave him a great and many-sided mind and a spirit which such minds often lack — the inspiration, the courage, and the honesty of the prophet who has walked on the mountain-top and swept the whole world with his eyes, and who can deliver a message that is as unbounded as his vision."

His health began to fail after the untimely death of his son, Revere, on the battlefield of Flanders. Osler remained a clinician to the very end, following his own case with careful observation. He knew that pneumonia in a 70-year-old was usually fatal, and it proved to be so in his case.

He had such an influence on his profession and his peers that, according to Dr. A. G. Gibson of Oxford " . . . some continue to test their conduct in a dilemma by asking the question, what would Osler have done." Indeed, his example has influenced me as a medicine program director more than 60 years after his death and is likely to continue to do so as long as I am responsible for the education of future physicians.

His photograph near my desk, a gift from distant kin, is a daily reminder of his standards of excellence, and a measuring stick for me to assess my own performance.

Reference

1. Cushing H. The Life of Sir William Osler, Oxford University Press, New York, 1940.

The personal story of the AMAA's new president highlights her past achievements and future challenges.

Third President From Georgia Takes the Helm of the AMA Auxiliary

EVELYN WARD GAY, ***Decatur****



Mrs. John G. Bates (Glenda), 1983-84 president of the American Medical Association Auxiliary.

When Mrs. John G. Bates (Glenda) of Cuthbert was installed as President of the American Medical Association Auxiliary on Wednesday, June 22, in Chicago, she became the third Georgian to hold the post. In 1928-29, Mrs. Allen H. Bunce served as president, and in 1947-48 Mrs. Eustace A. Allen held the position. Both were from Atlanta. Mrs. Bates is also the second youngest woman to be named to the top office in the 60-year history of the national organization.

As the new president, Mrs. Bates will be chairman of a Board of Directors which governs the activities of over 80,000 physicians' spouses from all sections of the United States. It will be her responsibility to preside at all meetings and take care of the business of the auxiliary in between. She will travel extensively during the coming year, attending state and county auxiliary meetings across the country.

Since her installation in June, she has returned to the Chicago office to take up her duties, and she will visit seven or eight states before October. In addition, she will represent the national auxiliary at the AMA's regular meetings and at some outside meetings such as those of the American Medical Political Action Committee (AMPAC), and the AMA's interim House of Delegates meeting in Los Angeles in December. At the mid-term board meeting to be held in January of 1984 at the AMA's new headquarters building in Washington, D. C., Mrs. Bates will participate in a legislation briefing and will become acquainted with the workings of the Washington office.

Already in the planning stages are several phases of the auxiliary's 1983-1984 calendar of important events. The fall confluence to be held in Chicago in October will bring together state and county auxiliary presidents and presidents-elect who will review projects to be put into operation during the year. As one of the major activities to be undertaken, the auxiliary will carry out the AMA's wishes to inaugurate an awareness project on child abuse over the

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, GA 30033.

nation, as a part of their program on children and youth. This will be the fourth step in the on-going umbrella called "Shape Up For Life." Past programs have covered nutrition, physical fitness, and stress.

Another project to be begun at the AMA's request will be support of legislation on drunken driving. Mrs. Bates will have the responsibility of approving and supervising distribution of all news releases on the subject which will go to state medical and auxiliary publications.

Cluster meetings, made up of all incoming state presidents and presidents-elect and nominees, will be re-instituted this year, and the first gathering scheduled for February, 1984, in Chicago, will be a training meeting for future leaders. The national president plans the programs for these sessions.



Dr. John Bates was present in Chicago when Mrs. Bates was installed as president-elect of the national auxiliary in June, 1982.

Personal Background

Mrs. Bates' involvement with the medical profession began in the summer of 1958 when she had just completed her freshman year on a scholarship at Bellhaven College in Jackson, Mississippi. As 18-year-old Glenda Walker from the small town of Mize, Mississippi, she went to work as a clerk-typist in the office of the Mississippi Baptist Hospital in Jackson. At church services one Sunday morning she was introduced to John Bates who was at home to visit his family from his medical studies at Tulane University in New Orleans. She turned down his first request for a date, however, when her family objected to the difference in their ages. He was 5 years older than she was.

For the time being, the romance came to an end with John Bates' departure to study that summer in Michigan. But upon his graduation from Tulane Medical School in June of 1960, he returned to Jackson to begin his internship at Mississippi Baptist Hospital. They were married in September of that year when she was a senior serving as secretary of the student body at Bellhaven College.

"We had an apartment halfway between the school and the hospital," she remembers with a smile, "and I drove him to the hospital every morning in our 1954 Chevrolet."

She was graduated from college in June of 1961 as the only married member of her class, and won the coveted Trustees' Award. With her degree in Spanish and business administration, the new Mrs. Bates gave up her plans for a bilingual position in the nation's capital for the job of a general practitioner's wife in the small town of Mendenhall, Mississippi, 30 miles from Jackson. They had gone there when Dr. Bates, who had previously been assigned to the Public Health Service in Tampa, Florida, was advised 6 weeks before his internship was over that his military obligations had been fulfilled, and he was being discharged after 8 years in the reserves.

For 2 years, Glenda Bates worked in her husband's office as a bookkeeper, and often made house calls with him where she assisted him by taking blood pressures. She especially recalls one hectic night during a flu epidemic when their car became stuck in mud during a pouring rain, and they had to walk a mile in search of a telephone. They never did reach the patient's rural home but were told later that he had just forgotten to tell them about the construction work going on in the area.

The town of Mendenhall was good to them, however, Mrs. Bates says. It was there that their first child, Jennifer, was born. But in May, 1963, at the request of Dr. Bates' friend and former classmate from medical school, they moved to Cuthbert, Georgia. With a fondness for her adopted hometown, she describes it as "a historical town of about 5,000 population in South Georgia, where there are many old houses built in the 1850s." It also is the location of Andrew Junior College. Dr. Bates had joined a group made up of 4 doctors. John Paul, their second child, was born after they moved to Cuthbert.

Mrs. Bates says that she enjoys small town life and believes it has been an excellent atmosphere in which to raise children. Since they are the only members of their families to leave Mississippi, the people of Cuthbert have become their families. The daughter, now married and the mother of a young son, is attending nursing school in nearby Albany and works part time in a hospital in Cuthbert and in her father's office. The Bates son is in a technical school at the present time and is an artist and designer of furniture.

Mrs. Bates calls herself "a professional volunteer." She has done volunteer work with civic groups for many years, serving as public education chairman for the Randolph County Heart Unit, a

division of the American Heart Association, for the local Cancer Society, and as Director of the Youth Sunday School Department of her church for 18 years. From 1964-1981, she studied voice with Mrs. B. T. Castellow, voice professor at Andrew Junior College and widow of the former U. S. Congressman from Georgia. At the First Baptist Church she is a soprano soloist and also serves as accompanist for the youth choir. She sings often for civic groups and medical auxiliaries and has performed several times in Little Theater musicals at Andrew Junior College.

Although there was a medical society in Cuthbert when the Bates family arrived there in 1963, there was no organized medical auxiliary functioning there. Dr. and Mrs. W. G. Elliott took them to their first MAG meeting in the spring of 1964, and Mrs. Bates became a member-at-large of the state auxiliary at the urging of Mrs. Elliott who had been president of that group in 1948. But Glenda Bates was expecting her second child at the time and could not be active in auxiliary work. Later, incoming state president, Mrs. John Meier of Albany, who served in 1964-1965, asked her to be state rural health chairman.

In 1967, Mrs. Bates and Mrs. Elliott reorganized an auxiliary of doctors' wives in the three counties of Randolph, Stewart, and Terrell, and Mrs. Bates became a regular auxiliary member. She also was named president of her local group that first year, and since then she has held every position in her county auxiliary several times. In 1973-1974, she served as President of the Auxiliary to the Medical Association of Georgia.

With her natural bent for leadership, Mrs. Bates stepped quickly up the ladder to become active in the national organization. She has been regional community health chairman, project bank area councilor for 2 years and director for 2 years, chairman of a task force to study the structure for young physicians' spouses' participation in auxiliary work, a member of the long-range planning committee for 1 year and chairman for 1 year. She was Southern Regional Vice President for 1 year, Vice President and chairman of membership for 1 year, and chairman of the bylaws committee.

As president-elect of the national auxiliary during the past year, she has traveled across most of the country representing the auxiliary and preparing for her upcoming role as president. But as busy as her schedule has been, she has continued to work in her husband's office. Since 1980, she has been fulltime business manager for what has now become a 2-man practice made up of Dr. Bates and his former classmate. She works with the office staff, handling personnel problems, monitoring the bookkeeping operation, and taking charge of investments. She says that she has "an excellent staff" who will be able to take care of the day-to-day problems of the office while she serves as the AMA Auxiliary's president. But she plans to keep in touch at all times and be back in the office when she is in town.

She looks forward to her year as president and sees many changes ahead for the national organization. "As the medical profession changes, so does the auxiliary," she says, "and our needs are greater." One change will be the election of a speaker and a vice-speaker of the Auxiliary's House of Delegates. The business of the auxiliary has become so involved and the demands on the president so great that a speaker has become necessary, she says. Next year's annual meeting will see the first speaker take office.

Another pilot project will begin in the spring in the New England states "to bring national to the grass roots" by holding seminars with auxiliary personnel and outside speakers.

Many of Mrs. Bates' friends and co-workers remember her chairmanship of the bylaws committee of the national organization as one proof of her outstanding ability to work with large numbers of people. She handled this important role with patience and diplomacy and afterwards gave her philosophy for dealing with such a diverse group of individuals. "Everybody has his own opinion," she says, "and I tried not to get on the defensive. The House of Delegates has to make and live with the decisions they make, and I was there to guide them and not feel intimidated."

Mrs. Bates declares that she loves people and the organization which she will serve for the next year. "One has to believe in anything in order to sell it," she says simply. "We can have an impact on American medicine and how it is viewed by the public. We are a potential storehouse of power in health education and in public relations." She especially is impressed and pleased with the Georgia auxiliary's latest project in health education, the learning center inaugurated this past year, which is being widely accepted and put into operation in several other sections of the country.

Her deep appreciation, she says, goes to the Medical Association of Georgia and its auxiliary for the leadership and encouragement they have given her. She is indebted to them for the excellent working relationship they have developed and considers her new job both an honor and a responsibility.

"This is a thrilling time for me both professionally and personally," she says. "I want the state groups to be proud, but anything I accomplish I will owe to them. They are the ones who deserve the credit. If it were not for them, I could not serve in this position."

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This study indicates that bariatric surgery in patients less-than-morbidly obese resulted in greater weight loss than in morbidly obese patients.

Gastric Bypass in the Less-Than-Morbidly Obese

CHARLES E. WILLS, JR., M.D., *Washington**

Abstract

Current bariatric surgery criteria generally exclude most less-than-morbidly-obese patients. Fifty-nine such patients, varying from 73 to 99 pounds over normal weight values, in a total series of 495, are reviewed and compared, in regard to weight losses and complications. Results suggest that slightly less-than-morbidly-obese cases should not be denied bariatric surgery.

Introduction

VIRTUALLY EVERY PUBLISHED paper on obesity surgery has claimed a weight criterion of 100 pounds over normal weight, or over twice the normal weight. This criterion has been termed morbid obesity.[1] However, many articles have contained a few cases that did not quite fulfill this requirement. What about the patient who is slightly less than 100 pounds over normal values? Should a patient with 99 pounds excess weight be rejected while another with 100 pounds excess weight is accepted? The purpose of this paper is to attempt to answer this question by investigating experiences with a number of cases in the less-than-morbidly-obese category.

Criteria for Obesity Surgery

Many published works have reported that limiting obesity surgery to subjects who are morbidly obese would involve only cases in which the outlook for optimistic life expectancy and for an acceptable quality of life is poor, thus justifying the dangers and complications of the surgery.

Another stated reason[2] is that since we have so many morbidly obese people, we should apply our time and efforts primarily to the ones who need it most. I am sure that peer criticism has plagued some surgeons in patient selection.

In spite of this, Mason[2] states "the criteria for acceptance of patients for gastric bypass are not carved in granite. In theory, as operative risk decreases the weight, criteria will become less stringent, and thus there will be more candidates who qualify. Specific criteria cannot be derived that will obviate the necessity for evaluation and the use of clinical judgement."

Another study notes, "Some patients have medical problems which are aggravated by obesity, such as hypertension, diabetes mellitus, pickwickian syndrome, or serious orthopedic problems and, therefore, many qualify for surgery at a lower weight."[3]

The general opinion at the Bariatric Surgery Colloquium[4] was that some less-than-morbidly-obese cases, especially those with additional medical problems, should be considered as candidates for gastric bypass.

Materials and Methods

Between May, 1977, and January, 1983, a total of 495 gastric bypasses for morbid obesity were performed at the Wills Memorial Hospital in Washington, Georgia. Fifty-nine cases did not meet the accepted definition of morbid obesity, but were from 73 to 99 pounds over normal weight values. The results of these cases in the form of weight loss and complications are evaluated and compared with a previous report which concerned the first 247 cases of all weights and also with all patients who weighed over 300 pounds.

Sex, Age, and Weight Loss Range Statistics

The patients included 55 white women, three

* Dr. Wills is from the Department of Surgery, Wills Memorial Hospital; send reprint requests to him at 119 Gordon St., Washington, GA 30673.

TABLE 1 — Results of Gastric Bypass Surgery on 55 Patients, May 1977 to March 1982, Washington, Georgia (Patients 73 to 99 Pounds Excess Weight)

Number of Patients	Preoperative Weight Kilograms	Preoperative Weight Pounds	Number of Months After Surgery	Average Weight Loss Kilograms	Average Weight Loss Pounds	Percent of Average Loss in Relation to Objective (20% Above "Ideal" Weight)	Percent of Excess Weight Loss
7	92	202	6-12	31	68	109	80
8	95	209	12-18	33	72	108	81
9	96	212	18-24	35	77	116	85
11	95	208	24-36	32	71	104	77
10	95	210	36-48	28	62	84	62
10	95	209	48-60	29	63	82	63

TABLE 2 — Results of Gastric Bypass Surgery on 114 Patients, May 1977-February 1981, Washington, Georgia

Number of Patients	Preoperative Weight Kilograms	Preoperative Weight Pounds	Number of Months After Surgery	Average Weight Loss Kilograms	Average Weight Loss Pounds	Percent of Average Loss in Relation to Objective (20% Above "Ideal" Weight)	Percent of Excess Weight Loss
33	117	258	6-12	40	80	75	56
35	120	263	12-18	39	85	76	58
21	121	266	18-24	41	90	83	60
25	107	236	over 24	37	82	91	68

black women, and one white man whose ages ranged from 20 to 64 years; average age was 35.7 years.

Table 1 shows weight loss in relation to time. As weight losses in obese people are difficult to evaluate statistically,[5] losses are listed as total weight loss, percentage of average loss in relation to an objective of 20% above ideal weight, and percentage of excess weight loss. Table 2 lists similar information previously published in a series of 247 gastric bypass cases of all weights.[5]

Complications

Table 3 lists the complications occurring in this group of gastric bypasses, Table 4 lists complications from a previously published[5] group of gastric bypass cases, and Table 5 shows those in patients who were over 136 kilograms (300 pounds) preoperatively. The number and degree of severity of such problems in these groups was compared, but no definite conclusion could be drawn. All groups had significant complications of a varied nature seen in most major surgical procedures. The less-than-morbidly-obese group, however, was the only one without an early mortality, leaking anastomosis, thrombophlebitis, or pulmonary embolus.

TABLE 3 — Complications in the Less Than Morbidly Obese — 59 Cases Washington, Georgia

EARLY	
Splenectomy	1
Pneumonia	2
Sepsis	1
Hemorrhage (ovarian vein related to vena cava clip application)	1
LATE	
Staple line breakdown	1
Ventral hernia	1
Dumping syndrome	5
Stitch abscess	1
Stomal stenosis	1
Drug addiction	1
Malnutrition	1
Revisions	9
Psychiatric treatment	1
Pneumonia (after second revisional surgery)	1
Death (not related to bypass)	1

Comment

Fourteen of the 59 cases had previous weight records that were over the accepted criteria (> 100 pounds) at some time in the past. For various reasons, including preparation for surgery, they lost weight before the surgery was done. It is interesting to note that many patients purposely gain weight in order to qualify (under the strict criteria) after being turned down for bariatric surgery.

The statistics showed lower weight loss in the groups 3-5 years after surgery. This may be because, generally speaking, their operations occurred earlier, at a time in the series in which gastric pouches were made larger. Also, in analyzing weight curves in these cases, results would often have appeared better if they had been judged at an earlier time, since some patients lost weight initially and then gained some of it back.

TABLE 4 — Complications of Gastric Surgery, May 1977-February 1981 247 Cases, Washington, Georgia

EARLY	
Splenectomy	5
Pneumonia, respiratory failure, and pulmonary embolus	9
Deaths — Pulmonary embolus	3
Intra-abdominal hemorrhage (treated conservatively)	1
Hepatitis	4
Sepsis jaundice and hemolytic anemia	1
Obstruction afferent loop	1
Persistent early regurgitation	18
LATE	
Staple line breakdown	6
Ventral hernia	3
Dumping syndrome	10
Wound infection and stitch abscess	4
Stomal obstruction	4
Revision	4
Marginal ulcer	3
Deep femoral thrombosis	2
Malnutrition	1
Persistent late regurgitation	3
Bypass takedown (patient dissatisfaction)	5

TABLE 5 — Complications in Patients Over 300 Pounds — 76 Cases Washington, Georgia

EARLY	
Splenectomy	2
Pulmonary embolus and atelectasis	5
Leaking anastomosis	2
Death	2
Superficial thrombophlebitis	3
Viral hepatitis	2
Hepatitis (post transfusion)	1
Transient outlet obstruction	2
Superficial dehiscence	1
LATE	
Ventral hernia	1
Dumping syndrome	4
Incisional abscess	3
Stomal stenosis	1
Revisions	5
Death (not related to bypass)	1
Marginal ulcer	2
Deep femoral thrombosis	4
Malnutrition	1
Coronary occlusion	1
Persistent vomiting	1
Recurrence of deep femoral thrombosis	1

In every series, a few cases take bizarre courses for unexpected reasons and consequently distort results. In this series, one patient had the gastric bypass by the author, then on the advice of another surgeon had the bypass changed to a gastroplasty. When this surgery was unsuccessful, the patient returned to the original surgeon to have the bypass redone, after which she became critically ill with pneumonia.

A second patient had gastric bypass surgery done uneventfully. Fourteen months later after a 35-kilogram (78 pounds) weight loss, she became ill and received treatment from other physicians, including two additional operations. When last contacted, she still had an incisional drainage.

A third patient was progressing nicely after gastric bypass surgery when an unusually severe case of influenza precipitated a series of complications including malnutrition, revisional surgery, and drug addiction.

The fourth patient originally had hiatal hernia repair and a gastric bypass. Good progress was made for 12 months until dumping syndrome symptoms began and became so severe by 16 months that revision surgery was performed. Following this, an adhesion from a loop of small bowel to the old hiatal hernia repair resulted in an esophago-jejunal fistula and subsequently an esophageal stricture. When last heard from she was doing well, but receiving esophageal dilations.

Conclusion

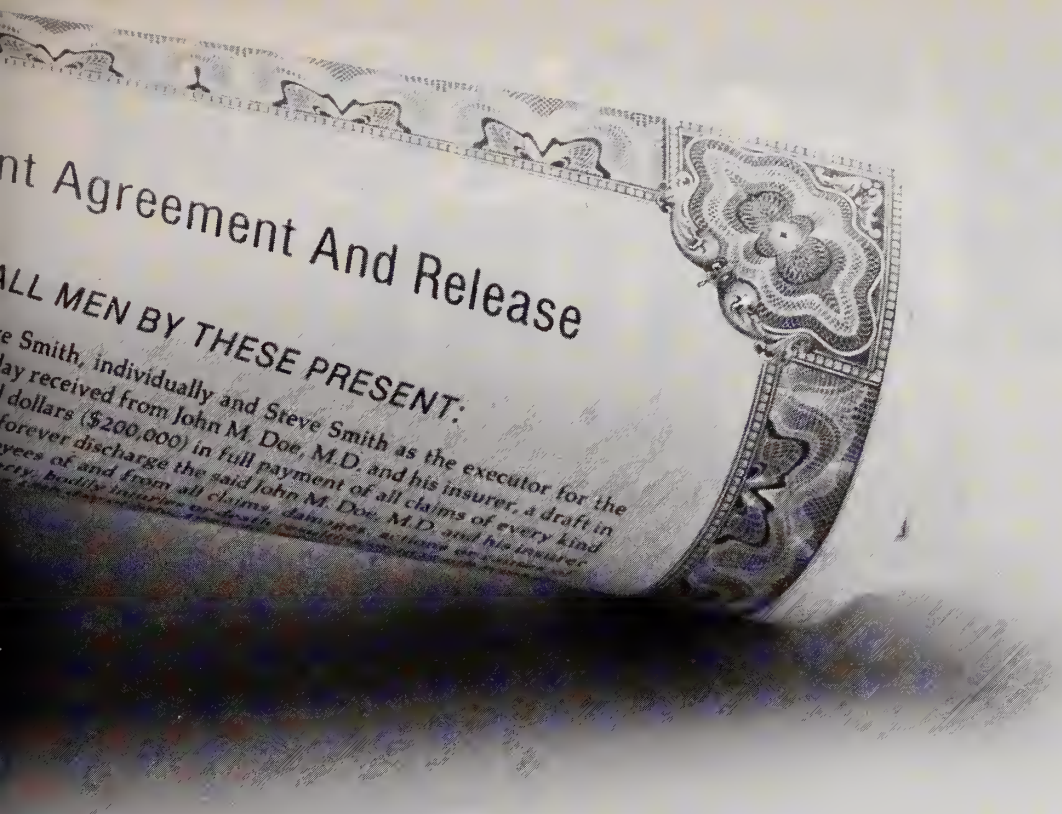
This study indicates that bariatric surgery in patients less-than-morbidly obese resulted in greater weight loss than in a series consisting primarily of morbidly obese patients. Since serious complications were recorded in all groups, definite trends could not be demonstrated.

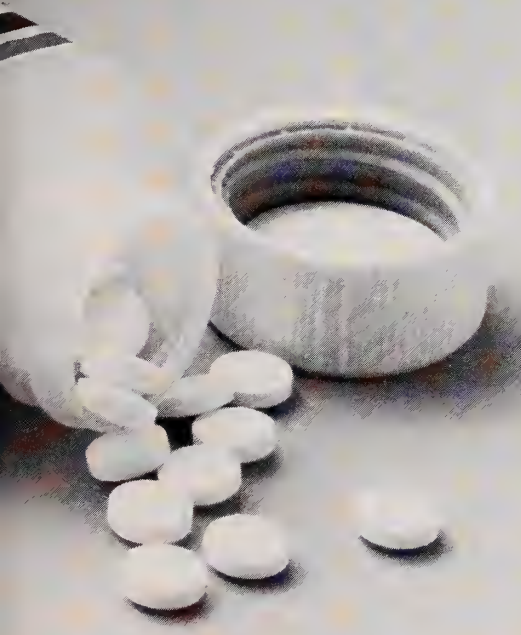
It is recognized that the series is far too small and periods of observation far too short to draw definite conclusions, but the study suggests that some less-than-morbidly-obese patients should be considered for gastric bypass surgery and possibly should not be excluded.

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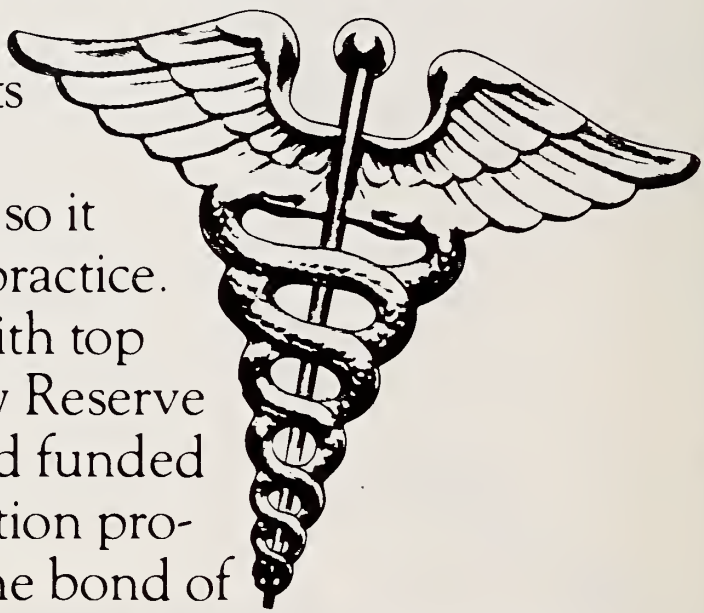
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Surgical Treatment of the Less-Than-Morbidly Obese: A Door Better Left Closed?

Dr. Charles E. Wills, Jr., has tremendous experience with the surgical treatment of morbid obesity, springing from hundreds of operations faithfully reported almost annually in the *Journal*. The student of morbid obesity will find useful information in these records of one surgeon's experience.

In his most recent paper, "Gastric Bypass in the Less-Than-Morbidly Obese" [in this issue of the *Journal*], Dr. Wills opens new doors. Morbid obesity has been defined as exceeding twice the patient's ideal weight. Right or wrong, it is an easily determined criterion which should not itself be "bypassed" lightly. I believe that his proposal for treatment of the less-than-morbidly-obese patient should be closely scrutinized.

Dr. Edward E. Masson,[1] one of the fathers of surgical treatment of obesity, recently presented some standards for gastric bypass. He agrees that candidates should be at least twice their ideal weight. Technically, he advises a stomach pouch 50 ml or less in volume, an outlet between the pouch and the distal stomach small enough to limit emptying and not to be stretched over time, and, of course, a secure partition between the proximal pouch and distal stomach.

Elective surgery requires definite guidelines to help the surgeon decide who is a candidate for surgery and what procedure is best. Only this way can unnecessary procedures be avoided. There are always gray areas requiring controversial decisions, but those areas should be kept as small as possible.

The surgical treatment of morbid or colossal obesity ranges from jejunoileal bypass, with several well known modifications, to gastric bypass or stapling, jaw wiring, and lately the biliopancreatic bypass of Scopinaro. Although the number of new procedures and modifications of old procedures increases each year, we still do not know definitively which procedure is best.

I agree with Ackerman[2] that a better understanding of etiologic and pathogenic factors is necessary for a rational management of both morbid and less-than-morbid obesity.

Not the least of our problems are the postoperative complications such as bleeding from the bypassed stomach,[3] perforation, peritonitis, obstruction, etc.

Buckwalter[4] has discussed the nonsurgical factors important to the success of surgery for morbid obesity. He emphasizes patient selection, the patient's desire for the operation, preoperative counseling, and finally, the probability of dietary compliance.

Despite the fact that much is written about the surgical treatment of obesity, I feel that somebody must initiate a committee or panel to re-discuss the problems of surgical treatment of obesity. Neither conservative treatment nor surgical procedures produces a permanent, satisfactory solution for the unfortunate obese patient.

An excellent, short and well written article by Dr. George Mann[5] would make a good basis for a panel discussion.

Last year, in my editorial, "Obesity and Surgery," I stated "Presently, it is impossible to say if the more easily performed jejunoileal bypass, with its metabolic problems, is better or worse than the gastric bypass, with its technical problems and early complications."[6] My philosophy has not changed.

Mao Tse-Tung, whom I did not admire, stated, "When the majority of the people have clear-cut criteria to go by, criticism and self-criticism can be conducted along proper lines, and these criteria can be applied to people's works and actions to determine whether they are fragrant flowers or poisonous weeds."[7]

We do need scientific criteria and more study for the taming of this shrew obesity. Standards of rigor, the idea of proof, the idea of logical necessity — all these things were described in ancient Greece. By all means, we must keep them.

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Atlanta

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Breast Reconstruction Following Mastectomy

JOHN BOSTWICK, III, M.D., *Atlanta**

THE BREAST is a powerful symbol within our society, evoking images of womanhood, sexuality, and maternity. Aesthetic, psychologic, social, and cultural influences all add to the complexity of this symbolism of a woman's breast to her femininity. Emphasis on this symbol is evident throughout history and is reflected today by artists and the media.

Breast cancer is the most common cancer in women; there were 110,000 new cases in 1982. Local surgical management of the breast cancer — the modified radical mastectomy — continues to be the standard and most frequently applied local treatment. Breast reconstruction after mastectomy for breast cancer can give a woman an opportunity for restoration of this primary symbol of her femininity. The reconstructive surgeon is now an integral member of the breast management team. It is reassuring for many women that they can have adequate local surgical therapy and also have their breast restored. The desire for breast preservation has led to alternatives to mastectomy, and clinical trials are now being carried out to evaluate lumpectomy and radiation therapy.

Breast reconstruction following mastectomy poses a multifaceted challenge to the surgeon. The final result must meet the patient's expectations and be attractive to her. This implies attractive and reasonably symmetrical breasts. The reconstruction should be complete and restore all areas of the mastectomy deformity. Simply placing a breast implant beneath tight skin is no longer acceptable. The infraclavicular area, anterior axillary fold, missing or tight skin, nipple-areola, and symmetry are all areas which require consideration.

Timing of the reconstruction is also individualized. Immediate reconstruction is reserved for highly selected individuals. Both the general surgeon and reconstructive surgeon should concur on proposed indications and techniques. The best results following breast reconstruction are achieved when the operation is done 3-6 months following the mastectomy. Adjunctive radiation therapy is not a contraindication to breast reconstruction. We prefer to wait, however, until after adjunctive chemotherapy to begin reconstruction. Many patients have had reconstruction 5-20 years after mastectomy.

The most commonly used technique of breast reconstruction involves the reconstruction of the breast mound with a silicone breast implant placed under the skin and muscle after a "modified" radical mastectomy. The reconstructive implant is behind the mastectomy wound and will not hide a possible recurrence.

After a radical mastectomy, additional skin and pectoralis major muscle replacement must be included in the reconstruction. A compound skin-muscle flap from the back, a latissimus dorsi musculocutaneous flap, provides the tissue needed for a

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Prepared at the request of the Georgia Division, American Cancer Society.

complete reconstruction. When the patient has a relative abundance of lower abdominal tissue, reconstruction can be done by transposing this tissue to the chest via a transverse rectus abdominis musculocutaneous flap. This technique uses the patient's own tissues and obviates a silicone implant. These flap procedures are major operations and are used only when sufficient tissue is not available.

Management of the opposite breast is also an important consideration, both from aesthetic and oncologic standpoints. When the patient is in the high-risk category for an opposite breast cancer, she may decide to have a prophylactic total mastectomy and bilateral reconstruction. Other options for the opposite breast include doing nothing, an augmentation mammoplasty, a reduction mammoplasty, or a mastopexy. Symmetry of the final reconstruction is a prime importance.

Nipple-areola reconstruction is usually done during a second operation a few months after the first stage. This provides the best opportunity to achieve symmetry. The usual source of nipple is the opposite nipple, or local chest tissues. A skin graft from the upper inner thigh provides a realistic areola reconstruction.

These reconstructive techniques are also applicable for reconstruction of other congenital or acquired breast deformities such as Poland's Syndrome. They are also applied for management of chest wall radionecrosis. Breast reconstruction has proved to be a significant contribution to the rehabilitation of some patients after local treatment of breast cancer.

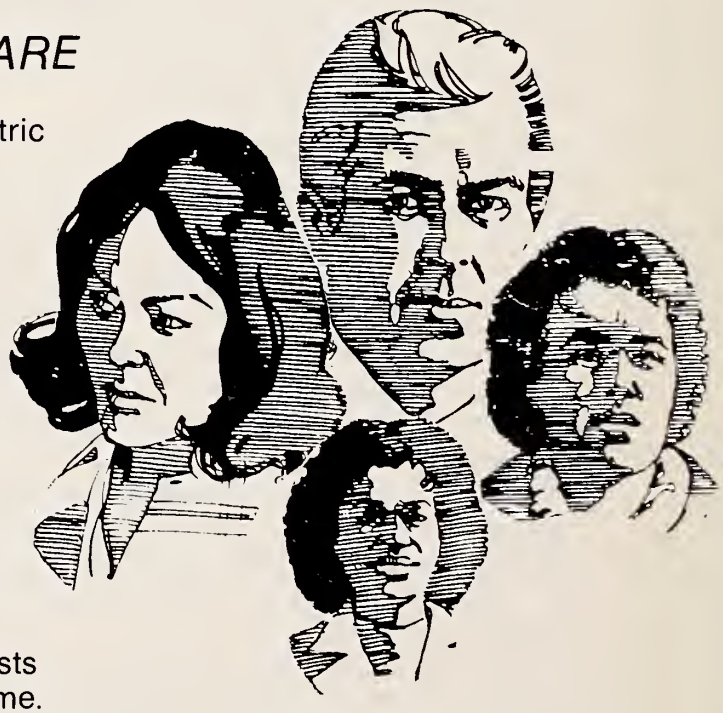
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Physicians' Counterclaims and Remedies Against Baseless Claims

DARYLL LOVE and ALLEN S. C. WILLINGHAM, *Atlanta**

YOU ARE A DOCTOR and have just been sued by a patient alleging that you negligently caused him injury and damage. It is your opinion that the patient cannot win his suit, because you have done nothing wrong, and no reputable physician will say that you did. You are convinced that you have been wronged by this baseless claim. Your reputation has been damaged, and you want legal relief. While a number of other jurisdictions have fashioned a remedy under such circumstances, and awards as high as $75,000 have been made to doctors sued in bad faith,[1] the remedies available under Georgia law are severely circumscribed.

Malicious Use of Civil Process

The cause of action under Georgia law which most nearly addresses the complaint of the hypothetical doctor is the action for malicious use of civil process. The doctor cannot sue the claimant based on mere negligence in the filing of the action. On the contrary, he must establish each of the following three elements:

(1) Malice on the part of the claimant in bringing the action,
(2) Lack of probable cause for bringing the action, and
(3) Special injury or special damage resulting from the baseless lawsuit.[2]

Further, the doctor's action for malicious use of process cannot be brought by counterclaim in the claimant's malpractice lawsuit. The doctor's complaint can be brought only in a subsequent action following the termination of the claimant's suit in a manner entirely favorable to the doctor.[3] The doctor's action cannot be brought so long as the claimant's action is pending, and it can never be successfully brought unless there is a favorable termination of the claimant's lawsuit. Moreover, the "special damage" requirement constitutes a major impediment to the doctor's suit. Unless the doctor is arrested or his property is attached, he must show some special damage which he has suffered as a result of the claimant's lawsuit. That special damage must be something other than humiliation, mental anguish, worry, suffering and fear, or being held up to public scorn and ridicule. Under Georgia law, the attorney's fees and expenses involved in the defense of the claimant's action are not such special damages as will support a claim based on malicious use of process.[4]

The great tactical advantage of proceeding by counterclaim is entirely lost when this action is used. The special damage requirement is very strict, and the difficulty of proving malice and lack of probable cause is considerable whenever technical

* Prepared at the request of the Medical Association of Georgia. Mr. Love is a partner and Mr. Willingham is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335. The subject of the original article was updated and expanded in an article appearing in the February/March 1983 issue of *The Atlanta Lawyer*. This article is a re-publication in substance of *The Atlanta Lawyer* article, reprinted with the permission of *The Atlanta Lawyer*.

medical conclusions are involved. As a practical matter, there are few doctors who are willing to take the additional time, trouble, and expense to maintain such an action following the conclusion of the action against them. For these reasons, such actions are seldom pursued; and yet, the malicious use of process remedy is the only remedy which addresses the substance of the doctor's complaint. If it appears inadequate, that is so only because of the expressed concern of the Georgia courts that litigants should be able to come into court without the fear that they may incur liability for having done so.

Abuse of Process

Unlike the remedy for malicious use of civil process, the abuse of process theory may be asserted by counterclaim in the same action with the patient's malpractice claim. In other words, there is no precondition to an abuse of process claim that there has been a favorable termination of the patient's lawsuit.[5] It appears, however, that the abuse of process remedy is not necessarily fitted to the doctor's complaint.

Unlike the malicious use theory, an action for malicious abuse of process is not designed to provide a remedy based on the bringing of a lawsuit by the claimant without probable cause. The malicious abuse remedy is more limited. It is designed simply to provide a remedy where a party has willfully misapplied the civil processes of the court in order to obtain an objective which the process was not intended by law to achieve. The malicious abuse remedy is available only when there is an ulterior motive coupled with an improper act in the use of legal process *after* it was issued, so that the abuse of the process amounts to a perversion of a lawful process to an unlawful end. In sharpening the distinction between malicious use of process and malicious abuse of process, the Georgia courts have made clear that the malicious abuse sanction is not to be applied to a claimant who maliciously causes a complaint to issue. Rather, it is designed simply to sanction the claimant who has afterwards made improper use of the civil processes for an ulterior motive.[6]

For example, if the patient properly observes the rules of the litigation system and pursues his claim without ulterior motives, he will not have abused process, no matter how baseless his claim was from the outset. It may be said that the malicious abuse remedy was designed to prevent abuse of the litigation system, not abuse of the litigant. The question of whether or not an abuse has occurred does not even address the basis for the suit. It does not question whether there is adequate basis for the suit, but rather whether the litigation of the suit proceeds in a proper way with respect to the material issues, as alleged.

For this reason, counterclaims have routinely been dismissed when they rely upon a malicious abuse theory based on the alleged filing and maintaining of a civil lawsuit in bad faith. The Georgia courts view such an action as one properly arising under the heading of malicious use of process, and such claims arising from the malicious bringing of the lawsuit, rather than from the malicious misuse of process after it has begun, cannot be asserted by counterclaim.

Therefore, the malicious abuse of process remedy will assist our hypothetical doctor only if there is some improper use of process after the inception of his patient's lawsuit. The doctor's real complaint — the bad faith initiation of a baseless claim — finds no remedy in the malicious abuse theory unless the patient's bad faith extends to his subsequent improper use of civil processes.

Defamation

The allegations contained in the patient's complaint may state that the doctor is unqualified and was negligent in having failed to comply with acceptable medical standards. Especially in cases where punitive damages are sought, the allegations against the doctor may attribute to him or her a measure of recklessness and indifference to consequences or other conduct which reflects adversely upon the

professional status of the doctor. For this reason, the doctor may look to the law of defamation for redress.

Again, the available remedy in Georgia is extremely limited. Although the allegations may have received broad publication in the press, considerations of public policy go far to curtail or eliminate any right of action which the doctor may have based upon defamation. All allegations and charges contained in a pleading filed with a competent court are privileged, however malicious and false they may be. As long as they are relevant and material to the cause of action, however baseless the action may be, they are absolutely privileged, and the allegations may be conditionally privileged even if they are not relevant and material.[7] Therefore, unless some scurrilous allegations are made extra-judicially by the malpractice claimant, the doctor will have substantial difficulty in successfully asserting any defamation action.

Lawyer's Malpractice or Ethical Violations

The doctor may feel that the true villain and the instigator of the baseless claim is not the patient, but the patient's lawyer. Because the patient's attorney does operate under legal and ethical rules and constraints, the doctor may, after defeating the patient's claim, consider filing a subsequent action against the lawyer based on his violation of those rules or his indifference to those constraints. The doctor may argue that the patient's attorney owes him some common law duty to avoid maliciously or gratuitously harming him.

This argument may be supported by reliance upon the ethical rules and directives which regulate the conduct of all attorneys. For instance, an attorney should not file a suit on behalf of a client when he knows or it is obvious that the particular action would serve merely to harass or maliciously injure another.[8] Further, it is a generally accepted ethical principle that a lawyer should not allow himself to become, on behalf of his client, an instrument for inflicting needless harm and expense upon another.[9] Neither vindictiveness nor the lure of substantial attorney's fees should promote bad faith litigation, as it is considered improper for a Georgia lawyer to encourage the commencement or the continuance of a lawsuit from any motive of passion or interest.[10] A lawyer should not, moreover, undertake any representation for which he or she is not competent or adequately prepared.[11] The latter consideration suggests that some investigation must be made by the attorney to confirm the validity of the lawsuit before it is filed.

In light of the heavy burdens which the law places on physicians, it is high time that the law recognize the correlative rights of the physicians.

On the other hand, most of these ethical and professional considerations and rules are aspirational in nature or are designed purely to provide guidelines for disciplinary action against attorneys by the State Bar Association. Such rules and ethical standards have been treated in Georgia as purely ethical guidelines which are not designed to provide a basis for a cause of action.[12] It is clear, moreover, that the Georgia courts will be very hesitant to create or recognize a duty running from the attorney to the adverse party. The attorney's duty to zealously represent his own client would appear to override any duty to an opposing party, or at least to create a conflict of interest.[13] Further, when acting as an advocate, an attorney has a duty to resolve in his client's favor all doubts as to the bounds of the law, and presumably this would apply to questions of the application of law to the facts of any individual case.[14] For all of these reasons, it seems unlikely that the doctor will be able to prevail in a subsequent action against the opposing attorney, or at least that it will take an extremely strong case involving egregiously reprehensible conduct before a Georgia court will recognize such an action.

Conclusion

A doctor who has been sued in bad faith and wrongfully charged with negligence should focus his attention on the goal of obtaining a decisive victory in that action. As long as the claimant does not abuse civil processes during the pendency of the suit and does not commit extra-judicial defamation of the doctor's character, the doctor will have no remedy against the patient until the lawsuit is concluded. At that point, the doctor may determine whether his vindication is complete, or whether a further action against the patient or the patient's attorney is advisable. Certainly, the Georgia courts have not shown any inclination to encourage litigation based on earlier wrongful litigation. Nevertheless, at least in cases involving special damages and unjustifiable conduct on the part of the patient or his attorney, it seems certain that the Georgia courts should fashion a remedy.[15]

The limitations placed upon the malicious use of process action have been created by judicial decision, and they can be removed by judicial decision. As presently defined, with its "special damage" requirement, this cause of action is ineffective to enforce the very rights which it purports to recognize. In light of the heavy burdens which the law places on physicians, it is high time that the law recognize the correlative rights of the physicians. The Georgia courts should review and liberalize the malicious use of process action to bring Georgia into line with the emerging national trend in this area.

Notes

1. *See, e.g., Raine v. Drasin,* 621 S.W.2d 895 (Ky. 1981) (award of $25,000 to each of two doctors affirmed); *Bull v. McCuskey,* 615 P.2d 957 (Nev. 1980) (award of $75,000 to doctor affirmed).
2. *Walsh v. Hibernia National Bank,* 160 Ga. App. 679, 288 S.E.2d 29 (1981).
3. *Cooper v. Public Finance Corporation,* 146 Ga. App. 250, 246 S.E.2d 684 (1978).
4. *Taylor v. Greiner,* 247 Ga. 526, 277 S.E.2d 13 (1981); *Greer v. State Farm Fire & Casualty Company,* 139 Ga. App. 74, 227 S.E.2d 881 (1976).
5. *Thomas v. Ronald A. Edwards Construction Company, Inc.,* 163 Ga. App. 202, 293 S.E.2d 383 (1982).
6. *Medoc Corporation v. Keel,* 152 Ga. App. 684, 263 S.E.2d 543 (1979).
7. *Finish Allatoona's, Etc. v. Burrus,* 131 Ga. App. 572, 206 S.E.2d 679 (1974).
8. *State Bar of Georgia, Rules and Regulations,* Directory Rule DR7-102(A)(1).
9. *State Bar of Georgia, Rules and Regulations,* Ethical Consideration EC7-10.
10. *Official Code of Georgia,* §15-19-4(5), formerly Ga. Code Ann. §9-601(5).
11. *State Bar of Georgia, Rules and Regulations,* Directory Rule DR6-101(A)(1).
12. *Tingle v. Arnold, Cate & Allen,* 129 Ga. App. 134, 199 S.E.2d 260 (1973).
13. *State Bar of Georgia, Rules and Regulations,* Director Rule DR7-101.
14. *State Bar of Georgia, Rules and Regulations,* Ethical Consideration EC7-3. *See Friedman v. Dozorc,* 312 N.W.2d 585 (Mich. 1981).
15. *See, e.g., Huene v. Carnes,* 175 Cal. Rptr. 374 (1981). Compare *Nelson v. Miller,* 607 P.2d 438 (Kan. 1980), with *Bull v. McCuskey,* 615 P.2d 957 (Nev. 1980). For a good review of the applicable authorities, *see O'Toole v. Franklin,* 569 P.2d 561 (Ore. 1977).



heart page
heart page
heart page

A Physiologic Approach to Pacing

JOSEPH W. RUBIN, M.D., C.M., *Augusta**

ARTIFICIAL CARDIAC PACING has become standard therapy for a wide variety of abnormal cardiac rhythms. For nearly 20 years, single chamber ventricular demand pacing has lengthened the lives of countless thousands of patients. In the beginning, heart block was the indication for implantation in over 80 percent of pacemaker recipients. Today, pacemakers are prescribed for symptomatic sinus bradycardia with and without AV conduction abnormalities, overdrive suppression of supraventricular and ventricular tachyarrhythmias, interruption of tachyarrhythmias, maintenance of cardiac output in cardiomyopathies, as well as various degrees of heart block. Greater device reliability and sophistication have paralleled increased use. Progressive miniaturization of components, long-lived sealed power sources, and solid state technology have combined to make pacemakers smaller, more reliable, and more responsive to physiologic needs.

To be "physiologic," a pacing system must preserve atrioventricular synchrony over a wide range of resting and exercise heart rates, and sense and respond to both normal and abnormal electrophysiologic events in both atria and ventricles. The achievement of optimal cardiac output for the entire gamut of normal physical activity is the ultimate goal. The variables which affect optimal cardiac output are rate, atrioventricular relationship, left ventricular function, and the ventricular response to exercise. An understanding of the role of these variables will clarify the concept of physiologic pacing and hopefully provide the background knowledge for selecting appropriate electrotherapy for patients in need of a pacemaker.

Rate and Cardiac Performance

Paroxysmal supraventricular tachycardia (SVT) in the absence of increased demand for cardiac output is frequently associated with a syndrome of weakness, shortness of breath, and chest pain. These symptoms are often combined with nausea, lightheadedness, palpitations, and anxiety even when such an arrhythmia happens by chance in an apparently healthy individual. In some, the accompanying sudden hypotension may cause syncope. The hemodynamic findings during SVT include an abrupt decrease in cardiac output by as much as 40 percent and a reduction in stroke volume to as little as 25 percent of normal resting values. The complaints of weakness, lightheadedness, dyspnea, and neurologic symptoms are easily understood in the presence of a sudden and precipitous decrease in cardiac output. In the absence of peripheral demand for cardiac output, venous return decreases due to compensatory vasoconstriction, and stroke volume plummets. Hemodynamic deterioration observed in SVT has been ascribed to decreased

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Articles for this Page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to the Page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

ventricular filling, AV valve regurgitation, and loss of AV synchrony. Overdistention of the atria may also unleash reflexes, causing hypotension and reduced myocardial contractility.[2]

The Effect of AV Synchrony

The preservation of a normal and physiologic AV interval is an important determinant of left ventricular ejection. Sequential atrioventricular pacing in patients with heart block results in a larger cardiac output than ventricular pacing at the same rate. In patients with normal conduction, left ventricular performance is depressed during ventricular pacing and returns to normal during sinus rhythm or controlled atrial pacing at equivalent rates. Both atrial and sequential AV pacing, unlike ventricular pacing, preserve a temporal relationship between atrial and ventricular systole.[7]

Basic to understanding the hemodynamic consequences of alterations in the AV interval is the effect of atrial contraction on closure of the AV valves, ventricular end-diastolic volume and pressure, and ventricular filling. The basis for hemodynamic abnormalities which often accompany complete heart block is an increase in end-diastolic volume due to increased filling time. Chamber dilatation is the acute adjustment to increased diastolic load, whereas hypertrophy is the chronic adaptation. Heart failure due to chronic heart block leads to chronic chamber enlargement, deterioration in ventricular function, and a decrease in stroke volume. The result is the inability of the ventricles to meet the metabolic needs of the patient.

The AV valves are normally closed by an atrial contraction properly timed before the onset of ventricular systole. However, in the absence of normal synchrony or effective atrial systole the AV valves are closed when ventricular pressure exceeds atrial pressure. This is associated with AV valve regurgitation and atrial distension. Restoration of correctly timed atrial systole eliminates regurgitation and lowers mean right and left atrial (filling) pressures.[1, 5]

Timing of atrial systole less than 50 milliseconds prior to closure of the AV valves causes a significant reduction in ventricular end-diastolic volume and a reduced stroke ejection according to Starling's Law. If atrial systole coincides with or closely follows ventricular systole, the accompanying reversal of vena caval blood flow, marked by large regurgitation waves, is most detrimental to hemodynamics. Hemodynamic deterioration is most pronounced when short cycle lengths (ventricular tachycardia) further compromise ventricular filling. The effect is less deleterious when atrial systole occurs at random during the cardiac cycle, i.e. in the absence of fast VA conduction (reentry). AV intervals between 100 and 200 milliseconds appear to produce the most favorable ventricular ejection. Stroke volume diminishes at AV intervals outside the optimal range.[6]

Left Ventricular Function and the Atrial Contribution

The curvilinear relationship between stroke volume and end-diastolic pressure describes the familiar Starling ventricular function curve. The actual contribution of atrial systole to ventricular stroke volume would appear to depend upon the level of end-diastolic pressure. When end-diastolic pressure is in the normal range, the curve is steepest, and the atrial addition should produce the maximum increase in stroke volume. When end-diastolic pressure is high, further increments in pressure due to atrial systole in the flat portion of the curve will have little additional effect upon ventricular ejection. In the presence of efficient left ventricular function, atrial systole should enhance stroke volume by as much as 20-25 percent.

When normal AV synchrony is maintained in patients without a history of heart failure using atrial or sequential AV pacing, atrial contribution depends upon preload. That is, the already familiar relationship between atrial augmentation of left ventricular output and filling pressure (or preload) is preserved. Switching from ventricular to atrial pacing at normal filling pressures produces a substantial atrial contribution to stroke volume. The same maneuver at a high preload causes little

change in ventricular ejection. Reducing preload with nitrates usually reestablishes atrial function.[3]

Exercise, Pacing, and Optimum Ventricular Performance

The cardiac output response during exercise with normal ventricular function is mainly supported by increments in heart rate. When heart rate is fixed due to heart block and constant rate pacing, prompt increase in cardiac output in response to exercise is mediated by rising stroke volume. Wide variations in cardiac pathology affect ventricular response to exercise, especially in patients with fixed ventricular rates. Under these circumstances, individual exercise capacity depends upon the paced rate. A ventricular rate of 80-90 per minute appears to optimize stroke volume in the majority. Lower rates are associated with a larger resting stroke volume and a correspondingly lower exercise reserve. Faster ventricular pacing encroaches upon the diastolic filling period, thereby limiting ventricular ejection.

At a standard work load, oxygen consumption is a direct function of stroke volume. During P-synchronous (VDD) pacing, subjects with heart block are able to accomplish standard work loads at lower stroke volume, lower oxygen consumption, and higher cardiac output in comparison with ventricular demand (VVI) pacing. VVD-paced patients increase cardiac output by relying more on sinus rate response than augmentation of stroke volume as do normal individuals. Lower initial stroke volume and lower oxygen consumption with VDD pacing leave a greater cardiac reserve for exercise in comparison with VVI pacing. Although adjustment in ventricular paced rate during exercise diminishes the differences between VVI and VDD pacing, the remaining superiority of VDD pacing is due to preservation of AV synchrony.[4]

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Acknowledgement

The author appreciates the assistance of DATASOFT SYSTEMS in the preparation of the manuscript.

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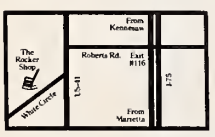
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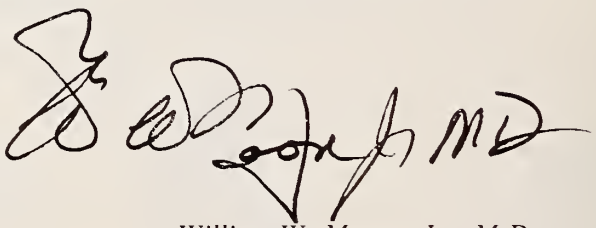


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We should all be very appreciative of the foresight and stick-to-itiveness of Ken Williams and Joyce Butler of the MAG staff who were primarily responsible for getting the program organized and giving us all the opportunity to bring it to fruition. My personal thanks to them and to the physicians, auxilians, and other volunteers who are helping us do what almost all of us have done individually over the years, but in a more effective, organized, and evenly distributed manner. The efforts of all these people have brought much needed medical care to the temporarily unemployed and credit to our association.



William W. Moore, Jr., M.D.

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Box 447, Warm Springs 31830

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315 Boulevard, NE, Ste. 100, Atlanta 30312

PERSONALS

First District

R. David Campbell, M.D., a family practitioner formerly of Dublin, recently opened a new practice in Americus.

Second District

Zenaida Capti-Magat, M.D., of Camilla, attended the American Academy of Pediatrics' Spring Session held in Philadelphia in April.

Sylvester physician, **H. G. Davis, Jr., M.D.,** was appointed by Governor Joe Frank Harris to represent the Second Congressional District on the Board of Human Resources for a 6-year term.

Fourth District

The American College of Physicians announced that **Gary Robert Botstein, M.D.,** of Decatur, was elected to Fellowship in the national medical specialty society. Dr. Botstein, a specialist in rheumatology, was honored during the Convocation ceremony at the College's Annual Session in San Francisco in April.

Fifth District

Nanette K. Wenger, M.D., of Atlanta, was appointed to serve on the Board of Governors of the American College of Cardiology for a 3-year term.

John H. Hartley, Jr., M.D., was recently elected treasurer of the Southeastern Society of Plastic and Reconstructive Surgeons at their annual meeting in Amelia Island, Florida. Dr. Hartley is a past-president of the Georgia Society of Plastic Surgeons.

Atlanta physician, **Alton V. Hallum, Jr., M.D.,** was named chairman of the Department of Obstetrics and Gynecology at West Paces Ferry Hospital.

William E. Silver, M.D., attended the Interspecialty Facial Surgery Congress for Aesthetic, Cancer, and Reconstructive Surgery held in New York City in April. He served on a panel entitled, "Implants for Facial Reconstruction."

Richard E. King, M.D., was recently elected to vice-president of The American Orthopaedic Association.

James S. Maughon, M.D., Director of Graduate and Continuing Medical Education, Georgia Baptist Medical Center, was elected into Alpha Omega Alpha.

Emory neurologist, **Herbert R. Karp, M.D.,** was named director of medical services for the Wesley Woods Center, the Atlanta campus of Wesley Homes, a Methodist-related organization for the aging.

Carl R. Hartrampf, M.D., and **Paul W. Black, M.D.,** received the James Barrett Brown Award from the American Association of Plastic Surgeons for the most significant contribution to plastic surgery literature in 1982 for their paper with Michael Scheflan entitled, "Breast Reconstruction Using the Transverse Abdominal Island Flap." The award was given at the Association's annual meeting in Boston in April.

The Emory University Chapter of Alpha Omega Alpha has placed three Georgia physicians on its graduate rolls. Alumni members are: **Brit B. Gay, Jr., M.D.** (Class of 1945), professor of radiology at Emory University School of Medicine; **Gerald F. Fletcher, M.D.** (Class of 1961), professor of medicine at Emory; and **Mark E. Silverman, M.D.,** an Atlanta internist.

Seventh District

William F. Wieland, M.D., was named Medical Director of Community Psychiatric Center's Peachtree-Parkwood Hospital in Atlanta.

Tenth District

Francis J. Tedesco, M.D., professor of medicine and chief of gastroenterology at the Medical College of Georgia, has received the Dr. Eddie D. Palmer Endoscopy Award for excellence in endoscopic research and contributions to gastrointestinal endoscopy. The award was presented during the 12th William Beaumont Gastrointestinal Symposium in El Paso, Texas.

DEATHS

Reuben Max Reifler

Reuben Max Reifler, M.D., aged 75, died May 13, after an extended illness. Dr. Reifler graduated from the University of Illinois. He practiced medicine in Macon for 41 years.

Survivors include his wife, one son, two brothers, and two grandchildren.

William Axel Smith

William Axel Smith, M.D., a retired neurologist, died April 29. Dr. Smith was 83. He received his medical degree from the University of Michigan. A pioneer neurologist, he was the first physician in the Southeast to limit his practice to neurology. Dr. Smith taught neurology at Emory University School of Medicine and was Emeritus Clinical Professor of Neurology since 1975. He was a senior member of the American Neurological Association and the American Academy of Neurology. He served as Chief of Neurology at Piedmont Hospital from 1926 to 1973 and consultant in neurology for the Disability Adjudication Bureau, Social Security Administration. He retired in 1979.

Dr. Smith is survived by his wife, two sons, and one brother.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from January through March, 1983.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Earl L. Alderman, Atlanta
Lawrence L. Allen, Thomaston
Benjamin S. Anderson, Cedartown
Daniel J. Appelrouth, Atlanta*
Manuel E. Artime, Tucker
Jack M. Bates, Gainesville
José Roberto Bejarano, Milledgeville*
Charles B. Bell, Decatur
Joel E. Berenson, Atlanta
Ralph E. Berggren, Macon
Donald S. Bickers, Atlanta*
Joseph A. Bishop, Calhoun
Marvin Blase, Atlanta*
Alonzo M. Boddie, Milledgeville
John Bostwick, Atlanta
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George T. Henry, Barnesville*
Braulio N. Hernandez, Milledgeville*
Fernando G. Hernandez, Warner Robins
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Alan Richard Hinman, Decatur
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Henry M. Labiche, Columbus
Dixon A. Lackey, Atlanta
Edward N. Laman, Atlanta
Scott I. Lampert, Atlanta
James F. Langford, Roswell
Henry LaSalle, Covington
José A. Lazarini Lugo, Fort Stewart*
J. Moultrie Lee, Savannah
John D. Lentz, Snellville*
Stephen B. Levine, Atlanta
Lawrence K. Lewis, Madison
Astor T. Lim, Brunswick
Malcolm N. Luxensberg, Augusta*
Mauro A. Manrique, Columbus*
Marvin L. Marchman, Norcross*
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Ollie O. McGahee, Jesup
Joel R. McKenney, Augusta
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Paul A. Robertson, Marietta
Donald R. Robinson, Macon
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Richard M. Rosenberger, Acworth*
Ronald O. Schwartz, Albany
Cheng-Hock Seah, Macon
Hugh K. Sealy, Macon
Robert A. Sears, Macon
Jayendrakumar J. Shah, Augusta*
George W. Shannon, Columbus
Stuart E. Sims, Atlanta
Robert M. Slayden, Atlanta*
Randolph R. Smith, Augusta
Oved Soffer, Atlanta*
Seymour O. Solodar, Smyrna
John T. Sosby, Newnan
Tommy K. Stapleton, Douglas
Eddie C. Starnes, Fort Gordon*
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Fred B. Thomas, Jr., Gainesville
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William A. Wood, Atlanta
Hugo J. Zee, Atlanta
Robert J. Zimmerman, Macon
George Zubowicz, Columbus

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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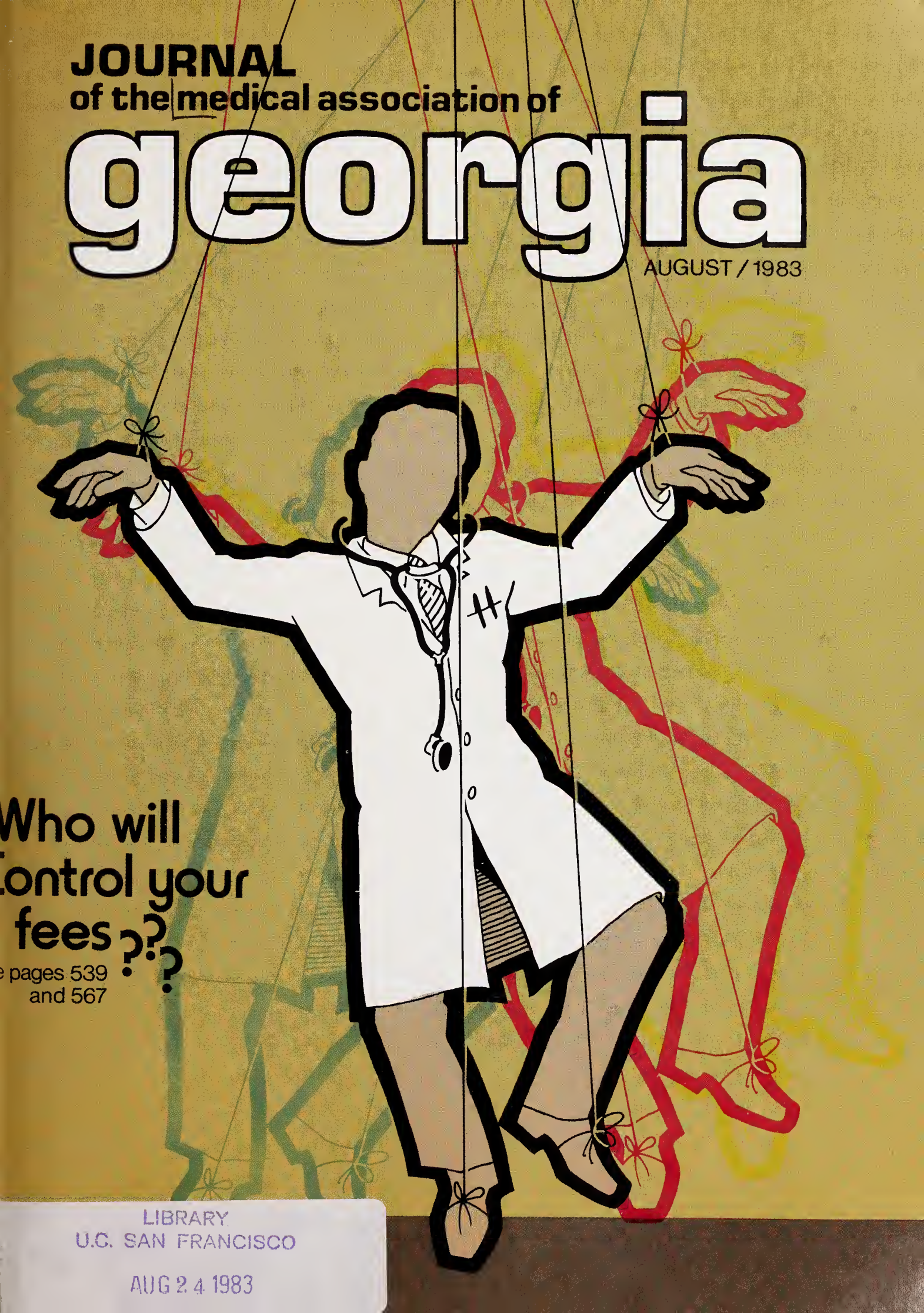
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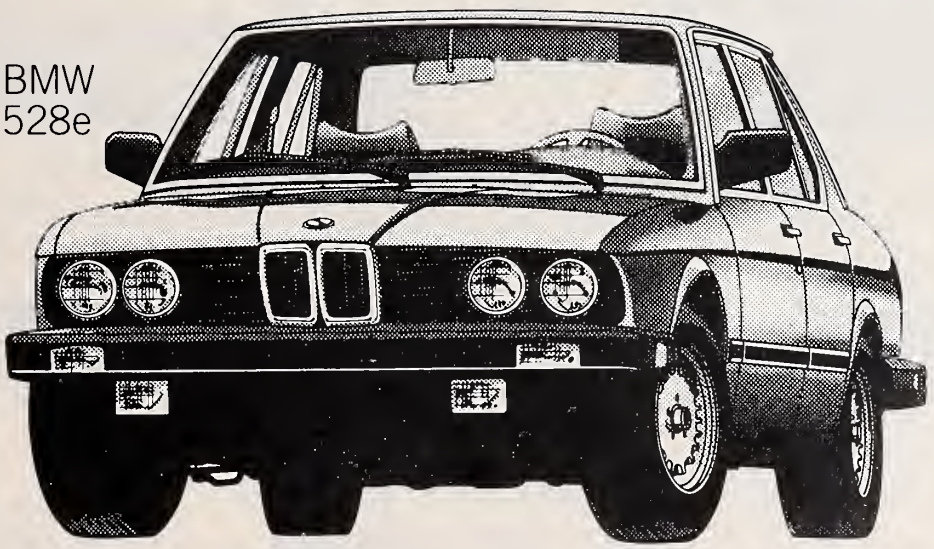
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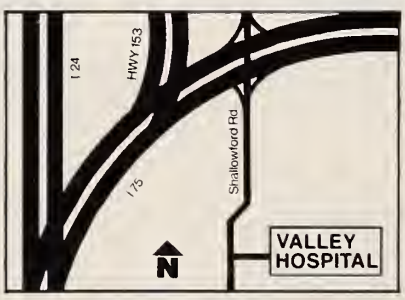


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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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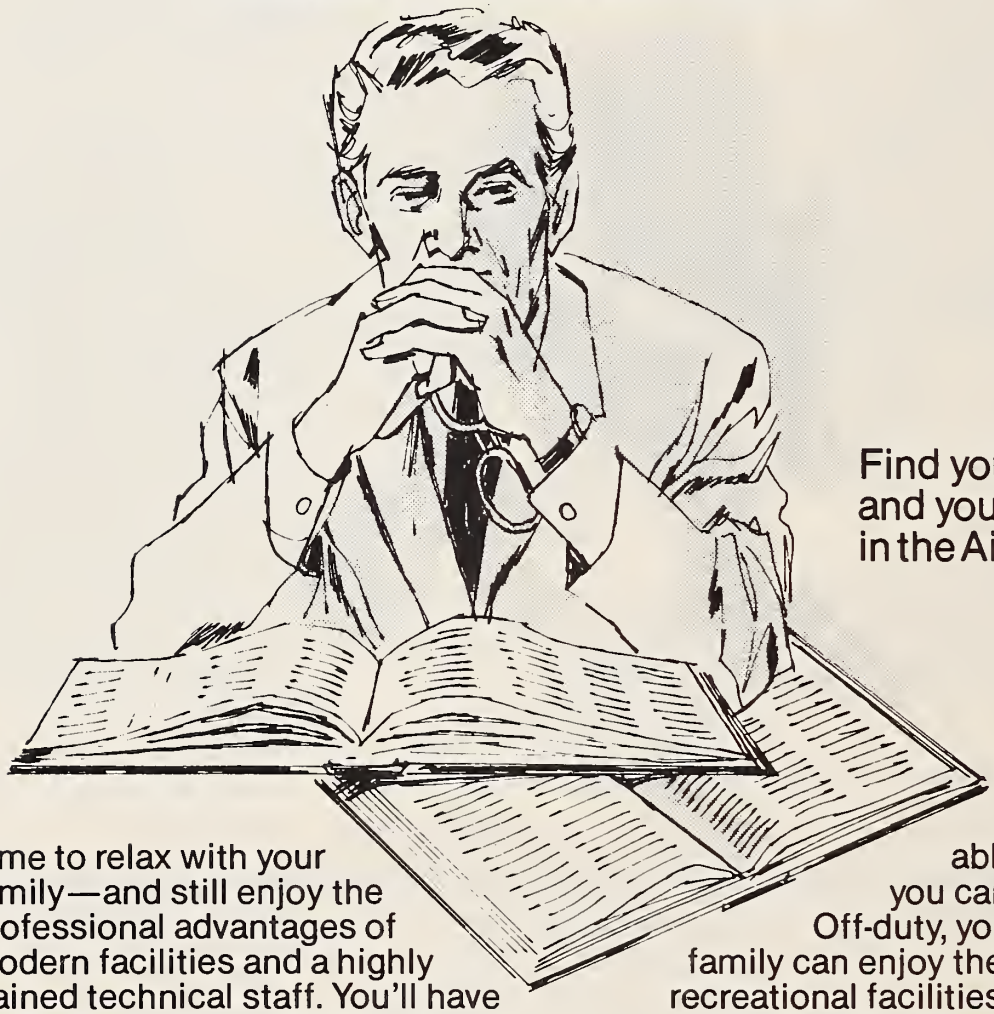
THE COVER

A new system for physician payment by third parties has been proposed by the AMA's Council on Medical Services: an indemnity-based system to replace the UCR (usual, customary, and reasonable) concept. The article on page 539 and Dr. Harrison Roger's editorial on page 567 discuss the facts and issues involving this new system which, if adopted, will ultimately affect the practice of every physician in the country. The AMA has directed its state associations to inform its members about the indemnity system and communicate the members' opinions back to the AMA's House of Delegates meeting in December of 1983. Read about the indemnity versus the UCR-based system in this issue of the *Journal* and communicate your opinion to your AMA delegate or local or state society.

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AIR FORCE

MEDICAL MEETING CALENDAR

AUGUST

21-23—*Atlanta:* **1983 Conference on Cocaine.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

24-28—*Hilton Head, SC:* **Summer Imaging.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

25-28—*Savannah:* **Georgia Psychiatric Association Annual Meeting.** Category 1 credit. Contact Samuel Brown, MD, 3280 Howell Mill Rd., Ste. 212, Atlanta 30327. PH:404/351-2330.

27-28—*Callaway Gardens:* **Medical Malpractice and the Anesthesiologist.** Category 1 credit. Contact William Hammonds, MD, Secy-Treas., Ga. Socy. of Anesthesiologists, Emory Univ. Hosp., Dept. of Anesth., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

SEPTEMBER

1-4—*Sea Island:* **Tri-State Otolaryngology Assembly.** Category 1 credit. Contact Warren Griffin, MD, Program Chairman, 800 1st St., Macon 31201. PH:912/743-8953.

2-3—*Sea Island:* **Ga. Chapter, American College of Physicians/Ga. Society of Internal Medicine.** Category 1 credit. Contact William C. Waters, III, MD, 35 Collier Rd., NW, Atlanta 30309. PH:404/355-1966.

11-14—*Sea Island:* **Annual Meeting—Georgia Urological Association.** Contact Richard C. Estes, MD, Secy-Treas, 35 Collier Rd., NW, Atlanta 30309. PH:404/355-0813.

12-14—*Atlanta:* **Echocardiography.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16—*Savannah:* **Neonatology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-17—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Secy-Treas, Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

23-25—*Atlanta:* **MAG Risk Management Seminar.** Cosponsored by Piedmont Hospital. Category 1 credit. Contact Denise Alper, Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta 30309. PH:404/355-7611, x3317.

26-29—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

6-8—*Hilton Head, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

7-8—*Atlanta:* **Gynecologic Oncology Update:** 1983. Co-sponsored by Georgia Baptist Medical Center and Georgia Division, American Cancer Society. AMA Category 1 and AAFP prescribed credits. Contact Arnold Bernstein, MD, Georgia Baptist Med. Ctr., 340 Boulevard, NE, Atlanta 30312. PH:404/577-1555.

8-12—*Atlanta:* **American Society of Anesthesiologists.** Contact ASA, 515 Bussee Hwy., Park Ridge, IL 60068. PH:312/825-5586.

10-13—*Atlanta:* **ACC Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Sea Island:* **Georgia Orthopaedic Society.** Category 1 credit. Contact William C. Collins, MD, 993 Johnson Ferry Rd., NE, Atlanta 30342. PH:404/255-4582.

14-15—*Columbus:* **MAG Risk Management Seminar.** Cosponsored by Muscogee County Med. Society. Category 1 credit. Contact Barbara Dent, Exec. Secy., Muscogee CMS, 232 Doctors Bldg., Columbus 31901. PH:404/322-1254.

16-21—*Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

19-22—*Hilton Head, SC:* **Fifth Annual Hilton Head Symposium on the Clinical Management of Diabetes and Endocrine Disorders.** Category 1 and AAFM prescribed credits. Contact Edwin D. Bransome, Jr., MD, Dept. of Med., MCG, Augusta 30912. PH:404/828-3445.

22-27—*Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P. O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

NOVEMBER

9-13—*Atlanta:* **Georgia Academy of Family Physicians Annual Scientific Assembly.** Category 1 and AAFP prescribed credit. Contact GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

11-12—*Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

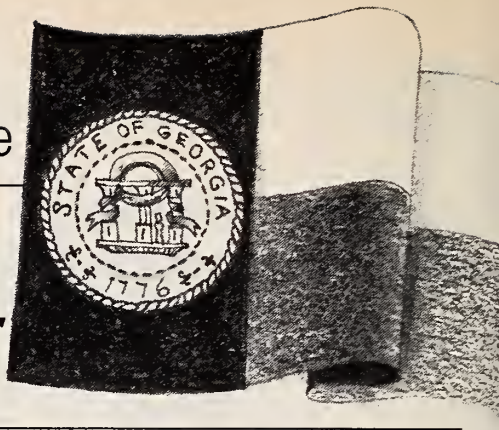
17-20—*Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester C. Lane, Exec. Secy., 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

18-20—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree Street, NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in GA).

30-Dec. 4—*Atlanta:* **Eighth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

Roche salutes the history of Georgia medicine

THE MODEST MAN OF MAJOR IMPORT



Dr. Crawford W. Long

One of the most important discoveries in medicine was the use of ether in surgical procedures, and its revelation was delayed because of the inordinate modesty of Dr. Crawford W. Long, its first successful user.

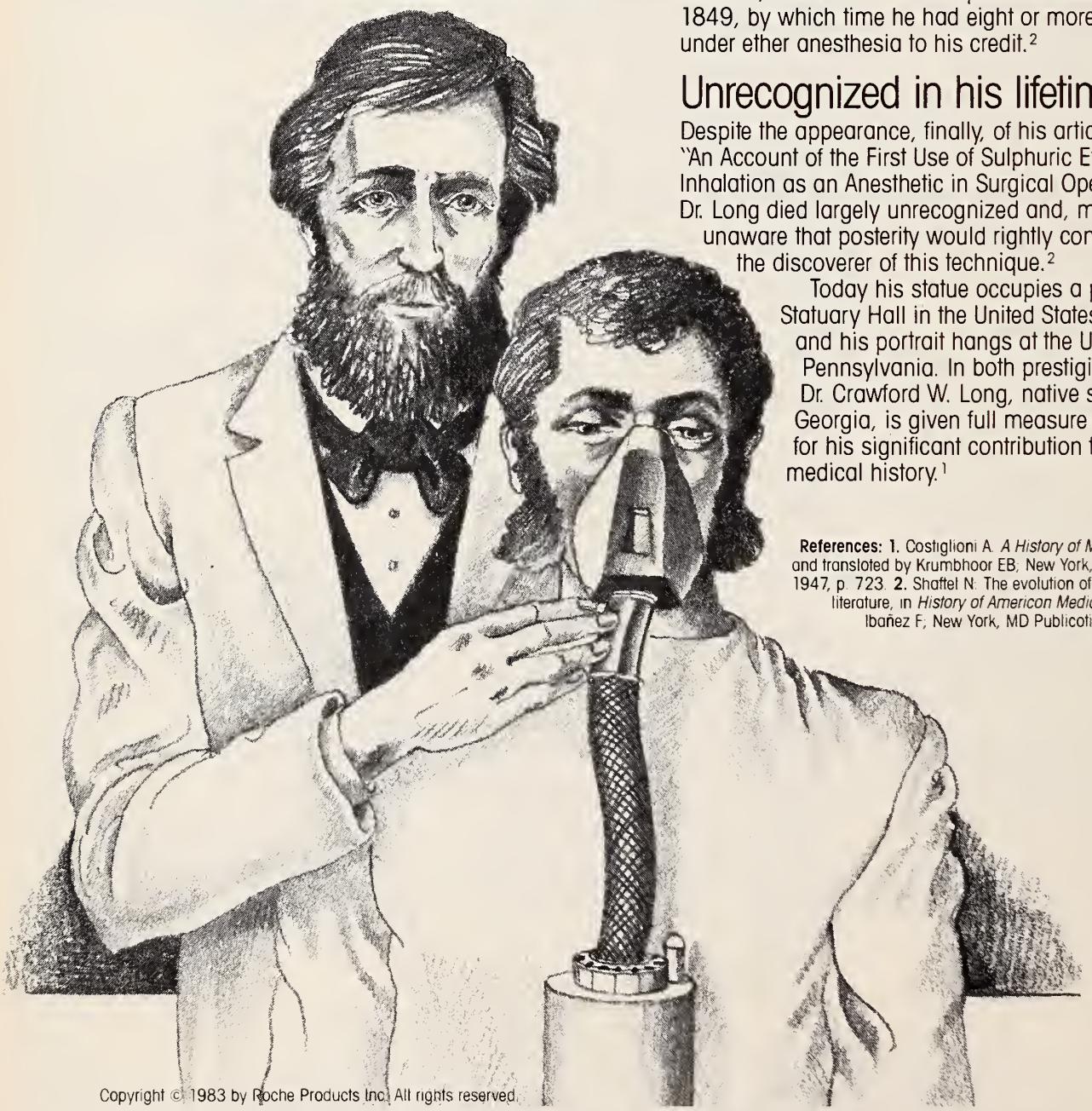
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Castiglioni A. *A History of Medicine*, edited and translated by Krumbhaar EB, New York, Alfred A. Knopf, 1947, p. 723. **2.** Shaffel N. The evolution of American medical literature, in *History of American Medicine*, edited by Morti-Ibañez F, New York, MD Publications, 1959, p. 107.

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- ☐ Early insomnia—91%
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- ☐ Gastrointestinal upset—73%

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Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Proctice of Medicine,* edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et al: Psychophormocology 61:* 217-229, Mor 1979. **3.** Data on file, Hoffmonn-Lo Roche Inc., Nutley, NJ.

In moderate depression and anxiety

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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JOURNAL
of the medical association of
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New Physician Payment System

AMA COUNCIL ON MEDICAL SERVICE*

At its June, 1983, Interim Meeting in Chicago, the American Medical Association considered the report and recommendation of the Council on Medical Services regarding payment for physicians' services. Specifically, the report centered on the three basic approaches to such payment — fee-for-service, capitation, and salary — and proposed an alternative to the "usual, customary, and reasonable" concept to establish the amount of third party payment. To obviate current and future problems associated with the UCR concept, an indemnity-based system for such third party payment has been proposed.

The following article discusses the facts and issues involved as reported to the AMA House of Delegates by the Council on Medical Services. This is an important subject, affecting the practice of every physician in this state and nation. The AMA has directed its state associations to inform its members on the indemnity system and communicate the members' opinions back to the AMA House in December of 1983. Read this report and contact your AMA delegate, county medical society, or the Medical Association of Georgia regarding your views on this subject.

Introduction

In the context of heightened concern about acceleration in health care spending and with exploration of alternatives to retrospective cost reimbursement for hospitals underway, increased attention is also being given by government, private payors, and the profession to the alternative methods under which payment can be made for physicians' services, and to the impact of each on the quality, accessibility, and costs of medical care.

In its Report K at the 1982 Interim Meeting, the Council alerted the House of Delegates to some of the problems for the profession seemingly resulting from use of the "UCR" [usual, customary, and reasonable] concept to establish third party physician payment levels, and further Council review of the entire subject of payment for physicians services was promised.** The purpose of the present report is to convey to the House the findings to date of that review. Specifically, this report will address two major issues:

I. Whether present Association policy on the general subject of payment for physician services continues to be appropriate in the context of the three basic approaches to such payment — fee-for-service, "capitation," and salary.
II. Whether, with specific reference to the "fee-for-service" approach, current and future problems resulting from use of the UCR concept to establish the amount of third party payment for physician services might be remedied by change to an indemnity-based system for such third party payment. (Such indemnity payments would represent a schedule of allowances and *not* a maximum fee schedule, with the physician charging the patient what he believes to be a fair and equitable fee.)

Synopsis

Present Association policy, which supports freedom of patients to choose their source of care and freedom of physicians to choose their method of payment — including fee-for-service, capitation, or salary — continues to be appropriate.

Within the fee-for-service approach, current AMA policy supports the basing of third party payment levels on the "usual and customary or reasonable" concept, and the majority of private and public payors use the "UCR" concept in establishing payment levels. However, the increasing costs resulting from this approach have caused both private and public payors to be caught between mounting pressure to constrain plan outlays on the one hand and continuing consumer demand for comprehensive coverage of physicians' services on the other.

As one result, the "reasonable charge" used by payors — particularly public payors — in determining payment

* This report of the Council was presented at the June 1983 Interim Meeting of the AMA House of Delegates in Chicago; John J. Ring, M.D., served as Chairman of the Council.

** Past House Action: I-82:187; I-81:148-150; C-68:199; A-65:54.

levels no longer reflects the actual charges made by most physicians, because of infrequent updating of fee profiles, percentile cut-offs on customary charge data, and annual percentage caps on prevailing charge increases.

In addition, pressure is increasing on physicians to accept the payor-determined reasonable charge as payment in full (except for allowed deductibles or coinsurance) — i.e., to become "participating physicians." Such pressure is exerted through:

- plan or company contracts which increasingly allow assignment of benefits or make payment only when services are provided by participating physicians;
- beneficiary misunderstanding of "explanation of benefit" letters and resulting patient/physician friction;
- "hold harmless" communications from payors to subscribers, and
- increased consideration nationally of mandatory assignment of fee schedules under Medicare.

As these trends continue, patients will be increasingly restricted to "participating" providers as a condition for insurance coverage. Eventually, physicians' remuneration will be determined solely by third party payors for the great majority, if not all, of the professional services they render — with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

Accordingly, the Council believes that the Association should seriously consider recommending that third parties change to an indemnity system of payment for physicians' services, i.e., paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, competition, and other relevant factors.

Such a change would benefit patients by:

- insuring their continued access to care not through external regulation of fees but through market forces;
- increasing both physicians' and patients' sensitivity to costs and quality of care provided;
- allowing them continued freedom of choice rather than being increasingly restricted to "participating" providers as a condition of coverage, and
- facilitating understanding and comparison of insurance coverages.

For third parties, rate determination would be simpler under an indemnity approach. Payors could establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges. Administrative costs should be significantly less. For government programs especially, it provides an alternative which permits budgetary restraints without further restrictions on type or duration of services covered or massive increases in enrollee copayment.

For physicians, this approach could bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. Uncoupling third party payment from physicians' charges could act to reduce legislative and political pressure for mandating physician "participation" as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

The Council believes that a change of this import in Association policy should be considered carefully by this House with their constituents over the next six months. The Council will also continue its study, and will submit recommendations at the 1983 Interim Meeting.

Is Present Association Policy on Basic Payment Mechanisms Appropriate?

There are essentially three ways in which a physician may be paid by patients, third parties, and/or employers for his professional services:

(1) on the basis of work done — or fee-for-service;
(2) on the basis of patients enrolled — or capitation; and
(3) on the basis of time spent — or salary.

In *fee-for-service,* or payment on the basis of work done, the physician's income varies in proportion to the services he performs. The total cost of care is not derived from a flat rate per person or a contracted number of physician hours at a set rate per hour, but rather from patient demand and physician response in each individual care episode.

In the *capitation approach,* a physician (or the group with which he works) accepts a fixed amount from a patient, in return for providing that individual all needed medical services over a specified time period.

The *salary approach* is, of course, a "time spent" mechanism. It can be payment by the hour, day, week, month, or year — payment which is independent of how many patients are seen or what is done for them.

The literature attempting to identify the incentives on professional behavior exerted by each of these payment approaches — and their impact on quality, accessibility, and costs of care — is extensive, and the arguments advanced in support of each approach are well known.

The Council believes that the AMA should seriously consider recommending that third parties change to an indemnity system of payment for physicians' services.

Proponents of fee-for-service note that the control of expenditures in this system lies primarily with the patient and physician rather than with external parties, and argue that this lack of superimposed financial constraint allows the physician to be much more responsive to each patient's differing needs and demands. Detractors of this approach claim that this same flexibility creates incentives toward overtreatment, and that it is more difficult to predict and budget for total costs of medical care, both for the individual and the third-party payor.

Advocates of capitation claim that this approach contains built-in disincentives toward overutilization of services, encourages greater emphasis on preventive care, and tends to reduce the incidence of hospitalization and other high cost services. They add that costs of care are much more predictable under a capitation arrangement. Opponents tar capitation with the other side of the same "utilization" brush, arguing that it fosters *under*-utilization of services in order to remain within budgetary constraints. They argue that, since payment depends on the number of patients enrolled, not on what is done for any one patient, the financial incentives act toward maximizing the patient list, and minimizing the amount of service per patient, with a resulting tendency toward risk selection and reduced access for high risk patients.

Salary arrangements offer perhaps the most direct control over the amount of physician reimbursement. Such arrangements can be attractive to physicians by providing steady incomes at acceptable levels, facilitating a regular work schedule, and providing a full range of fringe benefits such as vacation time, pension plans, and professional liability coverage. A salary arrangement also may be more feasible for some underserved communities which might not be able to support a fee-for-service medical practice — as witness the National Health Service Corps. On the other hand, patient needs could tend to suffer due to the time constraints of the physician contract, and physician productivity could be adversely affected, increasing the total costs of physicians' services in the long run.

In the Council's opinion, a comprehensive reexamination and analysis of the arguments for and against each payment approach would serve no useful purpose in this report. Each of these three approaches has its own inherent strengths and limitations, and — while fee-for-service has continued to be the dominant mode of physician payment in this country — no one method has clearly demonstrated its superiority for all patients or is most suitable for all physicians.

Further, the Council would emphasize that the financial incentives exerted by payment mechanisms *are by no means the only or even the primary determinant of physician behavior*. All three payment methods discussed above have built-in financial incentives toward inappropriate treatment — over-treatment in one instance and undertreatment or indifferent treatment in the others. Yet the Council strongly believes that most fee-for-service practitioners are conscientious in their attempts to provide only needed services, most physicians in capitation-type programs do their best to provide high quality care to all their patients, and physicians paid on a time-spent basis often continue providing care after the time paid for runs out.

Because concern for patients' needs is the primary motivation in physician behavior, the patient is best served by having a variety of health care delivery and financing mechanisms from which to select the source of his or her care. It is the view of the Council, therefore, that present Association policy on this subject, which supports (a) freedom for physicians to choose the method of payment for their services, (b) freedom of patients to select their source of care, and (c) neutral public policy and fair market competition among all health care delivery and financing systems, continues to be appropriate.

Is Indemnity Preferable to UCR-Based Third Party Payment?

The major source of physician payment under the fee-for-service approach has become the private or public third party payor. In paying on a fee-for-service basis, such payors use one of two methods to establish the amount they will pay the physician or the patient for a particular service.

Under one method, variously termed a *benefit schedule or indemnity* payment system, the third party pays a set amount for a given service, which is determined by the payor on the basis of claims experience, negotiation with the insureds in some cases, and public demand. Schedules of this type are used in many Medicaid and workmen's compensation programs and traditionally by the majority of commercial health insurance companies in their basic medical and surgical policies.

The alternate method for establishing the amount of third party payment under fee-for-service is to base the payment in some way on what physicians in the area usually charge for similar services — the *"usual and customary or reasonable"* concept. This UCR approach is used in some form by the entire Medicare (Part B) program, some of the Medicaid programs, most Blue Shield and other non-profit service plans, and most commercial insurance companies in their major medical and comprehensive policies.

In its Report K (I-82), the Council identified some of the problems it perceived as resulting from UCR-based third party payment, and indicated its intention to review this subject in depth. The remainder of this report conveys the results of that review to date, including comments received from state and medical specialty societies on the subject since the Council's Report K (I-82) was submitted.

Existing Association Policy

Since 1965, it has been this Association's policy that the "usual and customary or reasonable charge" concept should be the basis for establishing both government and private third party payments for physicians' services. The terms "usual," "customary," and "reasonable" were defined by the Association in 1968, as follows:

> **Usual** is defined as the "usual" fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee);
>
> **Customary** is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area;
>
> **Reasonable** is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question. (Resolution 48, C-68).

The inclusion of "reasonableness" as one of the three criteria for appropriate payment was intended to afford specific protection to the patient through the availability of medical society review and sanction in those cases where a particular fee was not justified by the circumstances.

UCR-based payment was first adopted on a local experimental basis by the Wisconsin Physicians' Service (Blue Shield) in 1954, at the urging of physician members. It became a statewide program in 1957, and was soon followed by similar programs in Iowa and California. By the mid-1960s, a number of Blue Shield plans as well as a few commercial insurors were using this payment methodology, although a number of others were hesitant to offer UCR policies because of lack of actuarial history and experience in establishing fee profiles. From 1966 on, adoption of UCR-based payment progressed much more rapidly — partly because a type of UCR methodology was mandated by the Medicare law and regulations for setting physician payment levels under that program, and carriers were thus forced to develop the capability to administer such programs.

As originally conceived and implemented, linking third party payment to physicians' actual charges offered a

number of advantages to both physicians and patients; it enabled payor recognition of charge differences based on individual training, skills, and experience, as well as differences by area; allowed charges to reflect changing costs on a continuing basis; and assured patients access to covered services without undue economic hardship.

Focus of CMS Concern With UCR

However, as such comprehensive coverage became more widespread, a degree of insulation of both patient and physician from concern with health costs occurred. The subsequent escalation in health spending is now a matter of prime concern in public and private sectors alike. This concern has been intensified by the legal restraints now imposed against any attempt by the profession to help control health costs through fee review. As this House is well aware, under terms of the order issued by the Federal Trade Commission in May, 1982, the AMA is prohibited from taking or espousing any action which would interfere with either the amount or the form of compensation provided a member in exchange for his or her professional services. The FTC order, together with court decisions holding that the use of peer review committees to determine the reasonableness of fees (Pireno, etc.) is not exempt from antitrust legislation, have had a chilling effect on professional fee review.

Caught between mounting pressure to constrain plan outlays on the one hand and continuing consumer demand for comprehensive coverage of medical services on the other, public and private payors alike are reacting in ways which, in the Council's opinion, make it essential to reexamine Association policy in this regard.

Specifically, two major trends have become evident:

- *Physician's vs Payor's Reasonable Charge* — the gap between the "reasonable charge" allowed by payors and the physician's actual charge is being widened;
- *Pressures Toward Participation* — pressures are increasing on physicians to accept the payors' version of the "reasonable charge" as payment in full — i.e., to become "participating" physicians — and to not bill the patient any additional amount (except for allowed deductibles and coinsurance).

These important trends form the basis of the Council's belief that unless there is a movement away from UCR reimbursement, *medicine could become the captive of third-party payors.*

Physician vs. Payor Reasonable Charge

The discrepancy between physicians' actual charges and those allowed under a "UCR-based" payment system is perhaps most striking in the Medicare program.

From the outset, Medicare's concept of "reasonable charge" differed from the profession's in several important respects. They differed, first, in definition. In contrast to Resolution 48 (C-68), Medicare defines a "reasonable charge" as the *lowest* of:

(1) the actual charge made by the physician rendering the service;
(2) the physician's "customary charge" for the service; or
(3) the "prevailing charge" for the service in that locality.

The "customary charge" is defined by Medicare as the individual physician's median charge for the service, an amount which would cover his charge at least half the times he performed the service. The "prevailing charge" is essentially the amount which would cover the "customary charge" for the service in that area *a certain percent* (90%, 75%, etc.) of the times it is performed. From enactment of Medicare until 1971, Medicare carriers were allowed to establish their own percentile cut-off for the prevailing charge — and set it as high as 90% in some areas. In 1971, the program changed from carrier-determined prevailing charges to a nationally-determined prevailing charge defined as the 75th percentile of customary charges for physicians of like training and skill, weighted by frequency, i.e., an amount which would cover the "customary charge" for the service in that area at least three-fourths of the times it is performed. Physicians are then paid 80% of the Medicare-defined "reasonable charge" for covered services to beneficiaries.

Medicare's approach also differs from AMA's UCR concept in that the amount of Medicare payments lag further behind current physician charges, since they are based on charge data up to 2½ years old. Both the "customary charge" and the "prevailing charge" are calculated from data on physician's charges during the calendar year before the fiscal year in which the claim is submitted; therefore, Medicare payments for most physicians' services are based on what the physician was charging 1-2½ years previously.

Under the indemnity system, a set amount for services rather than some proportion of the "usual, customary or reasonable" charge would be paid.

Finally, the two concepts differ in that, since 1976, the allowable yearly increase in Medicare payments is further limited by an "economic index" established by the Health Care Financing Administration. The "Economic Index" regulations of June 16, 1975, established a maximum percent of increase in "prevailing charges" allowable for any year over the prevailing charges in effect during fiscal year 1973. Thus, the allowed yearly percent of increase is limited not only by actual increases in physicians' charges but also by an economic index established by the Department of Health and Human Services, which is intended to reflect increases in the cost of doing business.

The index operates on the assumption that 40 percent of a physician's income goes to expenses and 60 percent to net income. It allows an expense-related increase in the prevailing charge based on data on salary increases in non-medical service industries, on increases in housing and transportation costs, on wholesale price increases for drugs and pharmaceuticals, and (for miscellaneous costs) on consumer price index increases. An increase in the net income component is allowed in proportion to increases in the earnings of production and nonsupervisory workers, adjusted to eliminate productivity increases. The "economic index" is calculated annually by HCFA and furnished to all carriers.

Since its inception, the yearly increases in prevailing charges allowed by the index have been generally less than the overall inflation rate, thus progressively increasing the gap between physicians' charges and Medicare payment.

For fiscal year 1984, the Administration has recommended a 1-year freeze on physicians' customary and prevailing fee levels — an even more stringent constraint on Medicare reimbursement amounts.

This progressively increasing discrepancy between physicians' costs and charges and Medicare payment* has been a major reason for the decrease in frequency of assigned Medicare claims since the program's inception. In 1969, physicians agreed to accept Medicare reimbursement as payment in full except for allowed deductibles and coinsurance in 61.5% of all claims; by 1980, that proportion had dropped to 51.5%. Most recently, 1982 year end data from AMA's Socioeconomic Monitoring System indicate that the proportion of assigned Medicare claims has dropped to 42%. These same data indicate that 69% of physician respondents identified inadequate Medicare reimbursement as an important reason for their not accepting assignment.

The discrepancy between actual charges and third party payment levels appears to be less across the other major source of UCR-based payment — the 69 Blue Shield plans presently in operation. According to Blue Cross/Blue Shield Association representatives, the majority of local plans use the 90th percentile, rather than the 75th as in Medicare, as the cut-off point for establishing prevailing charges. This may help account for the relatively high and stable rate of physician participation across those plans with participation agreements† reported by BC/BSA representatives — a rate averaging about 80%. However, two state medical societies did specifically communicate to the Council their concern with present or expected efforts by private payors to further restrict the amount payable under their UCR policies.

In addition, first quarter 1983 data from the AMA Socioeconomic Monitoring System indicate that 60% of those physicians electing not to enter into Blue Shield participation agreements in those areas where such agreements were offered did so because of insufficient reimbursement from the plan.

Pressures Toward "Participation"

Physicians are coming under increasing pressure to become "participating" providers — to accept the payor's version of the "reasonable charge" as payment in full and not bill the patient for any additional amount except allowed deductibles and/or coinsurance. Such pressure takes several forms.

1) *Refusing assignment or payment to non-participating physicians*

Virtually all of the contracts written by Blue Shield plans with participation agreements will allow assignment of benefits to the physician by the subscriber *only* if the physician has entered that participation agreement, will accept plan reimbursement as payment in full, and will refrain from "balance-billing" the patient. Non-participating physicians must recover their fee directly from the subscriber. As noted previously, Blue Cross/Blue Shield representatives expect most of the 10 local plans presently without participation agreements to attempt to institute such arrangements shortly. The Council has been informed that Blue Shield is changing or planning a change to this approach in Arkansas, Indiana, and Ohio, and may be considering it in other states as well.

Fee-for-service, capitation, and salary — each has its own inherent strengths and limitations. No one method has clearly demonstrated its superiority for all patients or is most suitable for all physicians.

Blue Shield of Massachusetts and some plans in the state of Washington apparently have a more extreme form of participation agreement, *wherein no payment is made to either physician or patient for services performed by a non-participating physician*. The Massachusetts program has been under litigation by the Massachusetts Medical Society for the past 4 years. Other medical societies are considering litigation against their state plans. At issue is whether, among other questions, Blue Shield can unilaterally refuse to honor assignments by enrollees to non-participating physicians, or refuse payment entirely for services of such physicians.

A review of existing state legislation in this regard is informative. Statutory excerpts from relevant state laws relating to freedom of choice of provider and to payment of such providers — for both medical service plans and commercial insurors — have been analyzed by the AMA Department of State Legislation.

According to that analysis, at least 32 states either allow or do not expressly prohibit non-profit service plans from issuing the above-noted contracts allowing assignment of benefits only to participating physicians. All states but one either allow or do not expressly prohibit such non-profit plans from making payment directly to subscribers for services of non-participating physicians. However, such plans are not as a rule *required* to make such direct payment to subscribers for services of non-participating physicians.

Stated another way, it would appear quite possible that, in many if not most states, applicable state legislation generally would not prohibit non-profit service plans from marketing contracts which would refuse payment *entirely* for service rendered by non-participating providers.

While commercial insurance companies are on the whole still subject to relatively stringent state prohibitions against any contractual restriction in the subscriber's freedom of choice, there appears to be relatively little statutory impediment to *non-profit medical service plans* in other states following the lead of those in Massachusetts and Washington.

2) *Misleading or inflammatory explanation of benefits to subscribers*

The Council has for a number of years been attempting to obtain improvement of private and public third-party communications to policyholders which, in the profession's opinion, provide an inadequate explanation of the insuror's methods of determining the benefit payable for a service and lead to patient misunderstanding.

The problem is especially severe currently in communications from private payors with UCR-based payment mechanisms, where the language used has often

* Nationally, Medicare disallowed 19.5% of total physician charges submitted for Medicare beneficiaries in 1977 (the most recent year for which data are available).

† About 10 plans presently have no participation agreements with area physicians. According to BC/BSA representatives, this number is expected to decrease fairly rapidly over the next few years.

conveyed the implication that any fee greater than the amount paid by the insuror is, by definition, "unreasonable." Compounding this problem has been the continuation in some areas of communications from both medical service plans and commercial companies to their policyholders with UCR-type coverage, offering to defend policyholders in any legal action brought by a physician to recover the amount of his fee not covered under terms of the policy.

Strong concern with both of these problems — misleading "explanation of benefit" language and "hold harmless" communications — have been a recurring theme in medical society comments to the Council on this subject. Again, however, legal constraints hamper any organized professional effort to deal with these problems through discussions with private payors, assistance in fee review, or similar activities. Such constraints led the Council to conclude, in its most recent report to the House on this subject, that "solutions must be found that do not require the cooperation of the health insurance industry or the medical service plans." (CMS Report F, I-81)

3) *Mandatory assignment under Medicare*

The past few years have seen increasing discussion in government sectors of the potential viability of legislation to mandate assignment as a condition of payment under Medicare, to require all physicians who treat Medicare patients to accept program reimbursement as payment in full, except for allowed deductibles and coinsurance, or to impose maximum fee schedules for services to beneficiaries. Such discussion will continue and further intensify as the present Administration seeks ways of paring a federal deficit now projected to reach $267 billion in 1988.

A more recent and perhaps even more significant development has been the enactment of legislation in Congress calling for development of a DRG-based prospective pricing proposal for *physicians' services* in hospitals, as a part of proposals for prospective pricing of hospital services under Medicare. At the time this report was written, a final version of Medicare hospital payment program based on diagnosis related groups (DRGs) had been approved by Congress and sent to the President. One provision of the new law calls for HHS to report in 1985 on the "advisability and feasibility" of applying DRGs to physician charges for hospital services and of legislation to effect such a change. (A more complete description of this legislation appears in CMS Report A, also before the House at this meeting.)

The Future

If the trends and forces identified above continue to operate into the future, the Council can foresee only one logical outcome:

- If the acceleration in spending for health care continues to be fueled by the insulation of both physician and patient from cost concerns . . .
- If unions, consumer groups, and the public continue to press for comprehensive coverage of physicians' services . . .
- If payors continue to react by marketing more UCR-based policies requiring physicians "participation" as a condition of payment — and consumers continue to purchase such coverage . . .
- If such mandated "participation" also becomes a part of the Medicare law . . .
- And if federal agencies continue to chill any professional attempts to deal with these problems through discussions and negotiations with payors . . .

Then medicine in effect will become the captive of public and private third party payors — as they already have in a number of other countries — in that their level of remuneration will be determined solely by those payors for the vast majority if not all of the professional services they render — with the resulting inevitable mediocrity in the quality of medical care.

The Council has concluded, therefore, that this is the proper time to reevaluate the Association's policy that UCR be the basis for all third-party payments to physicians. The Council wishes to emphasize that this reevaluation applies *only* to the basis for third-party payment, not to the more basic issue of how the individual physician in his own practice should establish his fees.

After substantial and in-depth consideration, the Council is of the opinion that serious consideration should be given by all third-party payors, government and private, to a change to *an indemnity system of payment for the majority of services provided by physicians,* i.e., paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, negotiation with insureds, and other relevant factors. As noted previously, these indemnity payments would represent a *schedule of allowances,* and *not* a maximum fee schedule; the physician would continue to be free to charge the patient what he believes to be a fair and equitable fee for his services.

The recommendation of indemnity-type payment methods makes even clearer the AMA's determination that third parties are and will remain separate and distinct from organized medicine, serving the patient rather than the physician.

The Council believes that such a change will be to the immediate and long-term advantage of patients, third parties, and physicians.

For patients, it will assure continued access to care *not* through external regulation of fees, but through the more effective mechanism of the marketplace, by increasing both physicians' and patients' cost awareness. The fee will again become the business of the physician and patient, with increased sensitivity by both to the quality and costs of care provided. This could, in fact, become an important "consumer choice" approach, since the patient will have a more substantial incentive to seek a physician whose fees are reasonably related both to patient satisfaction with care and to the amount Medicare or his or her private insurance pays, and to explore the reasons for differences in physicians' charges. It will allow patients continued freedom to seek the best in medical care, rather than being increasingly restricted to "participating" providers as a condition for insurance coverage. For those in the market for private insurance coverage, it will be much easier to understand and compare extent of insurance coverages — another "consumer choice" goal this Association has long supported. For Medicare beneficiaries as

well, selection of supplementary private insurance plans tailored more precisely to Medicare coverage "gaps" will be simplified.

For third parties, rate determination is simpler under an indemnity approach; payors can establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges; administrative costs should be significantly less. For government programs especially, it provides an alternative which permits more precise budgetary forecasting without further restrictions on type or duration of services covered or massive increases in enrollee copayments. For programs such as Medicare and national private health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to insure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For Medicare, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

Indemnity payments would represent a* schedule of allowances, *and* not *a maximum fee schedule.

For the profession, the Council believes that this approach can bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. *Uncoupling third party payment from physicians' charges will reduce legislative and political pressure for mandating physician "participation" as a condition of payment (which in effect would constitute a maximum fee schedule) and help preserve for the profession the continued freedom to charge what they believe to be a fair and equitable fee, subject to the normal and effective constraints of the market.*

The only exception to use of an indemnity-based approach to payment levels would be in the type of "catastrophic" coverage offered under both private and public payor programs where no further coinsurance or copayment is imposed once the beneficiary has spent a specified amount out-of-pocket. In order for such catastrophic coverage to provide meaningful protection to beneficiaries on the one hand and offer some degree of cost predictability to payors on the other, both the amount of patient spending allowed to count toward meeting the out-of-pocket spending limit and the amount of third party payments *in the catastrophic portion of their plans* should continue to be related in some way to the actual charges of physicians. To illustrate, if the plan was paying for physicians' services on an indemnity basis, the *entire difference between the indemnity payment and an individual physician's actual charge* — no matter how high — could theoretically be applied toward meeting the catastrophic threshold. In the Council's view, it would be more appropriate to allow only the difference between the indemnity payment and *physicians' customary charges* (or a certain percentile thereof) in the area to count toward the catastrophic threshold.

By the same token, once the catastrophic threshold is reached, most insurance plans currently do not pay *all* additional expenses incurred for covered physicians' services, but rather at a percentile of physicians' customary charges for these services, but without imposing coinsurance on the beneficiary. If a plan paid on a *flat indemnity basis* above the catastrophic threshold, some patients could continue to have major out-of-pocket expenditures for physicians' services. On the other hand, payment for *all* costs of physician services above the catastrophic threshold could be extremely expensive for the plan. Accordingly, the Council believes it would be desirable for payors to continue to relate their payment for physicians' services to physicians' customary charges *in the catastrophic portion of their plans.*

The Council recognizes that such a change to indemnity-based third party payment for most services provided by physicians represents a significant departure from past AMA policy. This is especially true in light of the fact that the UCR method of health insurance payment for physician services began with a major thrust from the sponsorship of state medical associations and, later, of this Association. However, as health insurance has grown, it has also become a strong and independent entity.

In the past decade, the AMA has given formal recognition to that independence by first, in 1976, discontinuing appointment of members to the national Blue Shield Association Board, and, second, by establishing the policy that the Association should avoid supporting a competitive advantage to any one type of health insurance company.

The Council believes this principle has served the Association well, and believes that the recommendation it makes here is a valid and appropriate extension of that policy. Further, the Council is of the opinion that the recommendation of indemnity-type payment methods makes even clearer the Association's determination that such third parties are and will remain separate and distinct from organized medicine, serving the patient rather than the physician.

This approach will not preclude the Council's continuing to meet with representatives of both the Blue Shield plans and the Health Insurance Association of America in efforts to improve the cost-effectiveness of medical care and in such *pro bono publico* efforts as the promotion of community health care coalitions.

The Council recognizes that this recommendation is one which third party payors may not choose to implement at once. For the service plans in particular, such a change represents a major shift in their approach to coverage for basic health expenses. However, the Council believes that in the long run it will not only be to the advantage of such payors, but that it leads the nation in the appropriate direction.

The Council also believes that a change of this import in Association policy should not be made precipitously, but that members of this House, and the Federation as a whole, should carefully evaluate for themselves the arguments for such a change before taking action.

Appendix
Questions Regarding UCR and Indemnity

Question

If private and public payors were to change to paying for physicians' services on an indemnity basis, what would prevent such payors from then requiring physician

acceptance of the *indemnity amount* as payment in full — in effect, converting such indemnity payment to a maximum fee schedule?

Answer

For the Medicare program, first, requiring all physicians who treat Medicare patients to accept program reimbursement (whether a "UCR"- or indemnity-based amount) as payment in full would require a change in the Medicare law. From the program's point of view, uncoupling payment levels from physicians' actual charges would reduce the need for such legislative change, since it would eliminate the continuing cost push on program spending exerted by UCR-based payment and allow much more predictable budgeting. It is true that, if Medicare changed to an indemnity basis, beneficiaries would probably exert political pressure to prohibit balance billing by physicians. *However, they are already exerting such pressure because of the growing discrepancy between Medicare's "reasonable charge" and physicians' actual charges.* In the Council's opinion, the only net political effect of changing Medicare to an indemnity basis would be to eliminate one of the important "justifications" advanced for such mandated assignment and ban on balance-billing — the assertion that "our payment is based on what most physicians charge anyway."

With regard to private payors, it should be remembered that what the Council is suggesting is a change to *indemnifying the patient* against health care expense; a contractual relationship would exist only between payor and subscriber, not between payor and physician. It could be a violation of the antitrust laws for service plans and commercial companies to market an indemnity plan which would pay only when the physician accepted the indemnity amount as full payment. As a practical matter, too, it would be difficult for such plans to survive in a competitive market, *since they could offer no assurance to subscribers of any reasonable level of access to covered services* — that is, few physicians would be likely to commit themselves to accepting as full payment an amount no longer contractually tied to actual charging patterns.

Question

Since unions and consumer groups have exhibited a strong and continuing preference for comprehensive, service-type benefits, will changing to an indemnity system drive more of them out of the fee-for-service sector and into alternative, capitation-type systems?

Answer

It is probable that the premiums for coverage under capitation-type systems will be generally *higher* than those for indemnity coverage under traditional insurance plans. A recent study by the Congressional Budget Office indicates that the average premium for HMO family coverage *now* is higher than that for traditional health insurance plans ($132/month for HMO coverage vs $104/month for all employment-based insurance). The tax law and other changes in the six AMA "consumer choice" principles presently supported by AMA would reduce the attractiveness of such more expensive coverage.

Even if premiums for the two types of coverage were comparable, a further shift to capitation-type programs should occur only to the degree that traditional systems are unable to compete on the basis of *either* price or quality/accessibility. But if traditional fee-for-service medicine offers a better product, patients will still be willing to pay more for it.

Question

If private and public payor levels are uncoupled from physicians' actual charges in an area, how would regional differences in cost be allowed for? In addition, would inflation act over time to make the indemnity allowances increasingly inadequate?

Answer

For programs such as Medicare and national private health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to insure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For Medicare, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

Question

If the Medicare program paid for physicians' services on an indemnity basis, how would this affect Medicaid?

Answer

A physician who treats a Medicaid patient and bills for his services is already required by law to accept the amount of the state agency's reimbursement as payment in full. Almost half the programs now pay on the basis of a fee schedule set by the state agency. Those states where payment is now the same as or a percentage of Medicare rates would have the option of establishing their own fee schedule or of keying payment to Medicare's new indemnity levels. To forestall even further reduction in access to care for beneficiaries in these latter states, consumer and professional groups would need to continue and perhaps intensify their advocacy for reasonable Medicaid payment levels.

Question

Will the majority of physicians in fact be willing to now deal solely with the patient in fee matters, or will they continue to prefer to accept a lesser but "guaranteed" payment from the third party?

Answer

The Council believes this is a key question. The Council further believes that the majority of physicians will choose to make this change, if they perceive clearly the long-term adverse consequences of not doing so.

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Though chemonucleolysis is not new, it is the first time that this therapy will be employed on a large scale in this country to treat lumbar disc disease.

Treatment of Herniated Lumbar Discs With Chymopapain

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CHYMOPAPAIN** has been approved by the Food and Drug Administration (FDA) for the treatment of patients with herniated lumbar intervertebral discs. Though chemonucleolysis is not new, it is the first time that this therapy will be employed on a large scale in the United States for the treatment of lumbar disc disease. Consequently, it is felt that a brief review of the subject might be beneficial.

Historical Aspects

Chymopapain is a proteolytic enzyme derived from the crude latex of carica papaya and was first isolated by Jansen and Ball in 1941.[4] In 1956, Louis Thomas administered crude papain intravenously to rabbits and observed that their normally rigid ears wilted and collapsed apparently as a result of digestion or disintegration of the matrix of the hyaline cartilage of the ear.[3] Intrigued by this observation, Dr. Lyman Smith, an orthopedic surgeon, decided to use the agent to dissolve the nucleus pulposus of intervertebral discs. Having shown that chymopapain would cause dissolution of the nucleus pulposus in rabbits without apparent effect on the surrounding tissues, such as ligaments, bone, nerve roots, and dura mater, he then injected chymopapain directly into the discs of 22 dogs with paralysis of the hind legs believed to be due to herniation of intervertebral discs. Fourteen of the 22 dogs recovered to the extent of being able to stand and walk. After these animal studies, Smith was the first to inject the enzyme into the disc of a human subject in 1963. He reported good results of the treatment in 8 of 10 patients with signs and clinical findings of herniated lumbar discs in 1964.[14]

From 1963 through August of 1975, more than 15,000 patients received intradiscal injections of chymopapain (Discase®, manufactured by Baxter-Travenol Laboratories).[2] However, in August of 1975, the Food and Drug Administration (FDA) prohibited the use of chymopapain for treating herniated lumbar disc, and Baxter-Travenol Laboratories withdrew its application for drug approval. The FDA's decision was a highly controversial one, and was, at least in part, based upon the results of a double-blind study done in four centers which failed to show a substantial benefit of chymopapain over placebo.[5, 9, 12, 13] This study has been criticized widely on several counts: early code break, limitation of dose per disc to a fixed amount, and lack of true placebo control.[9] Nevertheless, for the past 7 years, many patients have received chymopapain chemonucleolysis (CC) in Canada and Europe, and reports of its efficacy have continued to appear.[7, 8] More recently, Smith Laboratories has sponsored a multi-center, double-blind, placebo (saline) controlled trial at seven medical centers which showed an 80% success rate with chymopapain versus a 57% success rate with placebo at 6 weeks. Following this, an open-label trial involving 32 investigators at 28 hospitals within the State of Illinois was initiated, and interim data on the first 420 patients suggests a beneficial effect from the drug. These two studies have served as the impetus for the recent release of the drug by the FDA.[15]

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** Chymodiactin®, manufactured by Smith Laboratories, Northbrook, Illinois.

Pharmacology of Chymopapain

Chymopapain acts on the chondromucoprotein of the nucleus pulposus by rapidly hydrolyzing the substance to mucopolysaccharides and polypeptides. In the doses employed therapeutically, it does not alter collagen. Immediately after injection, the strongly positive charge of the chymopapain molecule interacts with the negative charge of chondromucoprotein and binds the drug to the disc tissue. There is a rapid reduction in viscosity of the nucleus pulposus, and this theoretically reduces the intradiscal pressure. After injection, a temporary rise in the urinary excretion of acid mucopolysaccharides occurs.

Garvin has experimentally evaluated not only chymopapain, but papain bacterial protease, trypsin, and collagenase in experimental models.[3] In mice, chymopapain was found to be the least toxic of these substances when injected into the disc, as it did not have an effect on the annulus fibrosus. Likewise, doses of up to 100 times greater than those required to dissolve the nucleus pulposus in mice were well tolerated when injected intravenously, intradiscally, or epidurally. Large doses injected intrathecally, however, caused subarachnoid hemorrhage secondary to rupture of numerous thin walled vessels in the pia arachnoid. This effect is more pronounced with injections at the cisternal as compared to the lumbar area. However, later histologic study of survivors has shown no evidence of arachnoiditis. In these studies, Rhesus monkeys tended to tolerate injection of chymopapain into the subarachnoid space better than lower animals (rabbits and dogs). These investigators also showed that there were no morphologic or functional changes in nerves which were bathed in solutions of chymopapain, and that the active enzyme was rapidly inactivated by $\alpha 2$-macrogobulin in the plasma and cerebrospinal fluid.[3]

Because chymopapain is a protein of relatively low molecular weight, it initiates antibody production when injected into man. Though it is a relatively weak antigen (about 1/40 as anaphylactogenic as horse serum), it may cause anaphylaxis when used for chemonucleolysis.[16] Theoretically, anaphylaxis would be more prone to occur if the substance was injected a second time.

Patient Selection and Indications for the Procedure

Chymopapain chemonucleolysis (CC) should be reserved for those patients in whom the surgeon could confidently expect a good result from laminectomy and diskectomy. In general, patients who are candidates for the procedure would include the following:

1. Those with symptoms of radicular leg pain, and back pain of acute, subacute, or chronic variety, who have not responded to at least 3 weeks of conservative measures in the form of strict bed rest, analgesic agents, and muscle relaxants.

2. Those who complain of paresthesias in a dermatomal distribution consistent with irritation of the L4, L5, or S1 nerve roots.

3. Those who on examination have positive mechanical signs which may include paraspinous muscle spasm, scoliosis, limitation of range of motion of the back, positive straight leg raising, or crossed straight leg raising test or a positive popliteal compression test and who may also have tenderness to palpation over the lower lumbar spine.

4. In most instances, those who have either wasting or mild weakness in the distribution of the nerve root involved, and absent or diminished knee or ankle jerk, or diminished sensation to pinprick in the dermatomal distribution of the nerve root involved.

5. In all instances, those who have evidence of a protruded or ruptured lumbar disc either by CT scanning or lumbar myelography or both.

In summary, the ideal candidates for CC are patients: (1) that have clinical evidence of a soft lumbar disc protrusion with signs directed to the appropriately compressed nerve root; (2) that have disc protrusion documented by standard diagnostic procedures such as CT scanning and/or myelography; and (3) that have failed conservative therapy including bedrest, analgesic agents, muscle relaxants, etc. It is obvious from the foregoing that ideal candidates for chymopapain injection are also ideal candidates for surgery, i.e., lumbar diskectomy. Use of chymopapain should be restricted to physicians experienced and trained in the diagnosis of lumbar disc disease and all acceptable treatment modalities including surgery.

Definite contraindications to CC include:

1. Known sensitivity to chymopapain, papaya, or any meat tenderizer. If a patient has previously had an injection of chymopapain, a second injection should not be made because of the risk of anaphylaxis due to hypersensitivity stimulated by the first injection.

2. Pregnant patients.

3. Children.

4. Sphincter disturbances and/or rapidly progressive lower extremity muscle weakness due to a disc protrusion with compromise of the cauda equina. In this situation, an immediate surgical diskectomy with decompression of the compromised cauda equina is the appropriate procedure.

5. Extensive spondylosis or spinal stenosis caused by bony spurs secondary to degenerative arthritic changes of the lumbar spine, or spondylolisthesis.

6. A demonstrated "complete block" on myelography or a myelographic appearance that suggests a spinal cord tumor.

7. Cervical and thoracic disc disease.

Less clear-cut or relative contraindications for chymopapain therapy include the following:

1. A woman with an elevated sedimentation rate. The rationale behind this recommendation is that while the incidence of anaphylaxis after injection is less than 1%, it does occur more often in females with elevated sedimentation rates. There is also some evidence that females should not be treated during a menstrual period.[16]

2. A previous surgical diskectomy at the currently symptomatic level.

3. Patients who have a workman's compensation claim pending. In general, these patients have fared less well than the non-compensation worker with open lumbar diskectomy, and the same situation can be assumed to exist with CC. Thus, these patients must be evaluated individually on their own merit. As well, patients involved with litigation claims or having a psychiatric disturbance must be analyzed carefully and treated only after pursuing all therapeutic options.

Pre-Treatment Preparation

If lumbar myelogram has been a part of the patient's pre-operative diagnostic workup, it is well to delay CC until 2-3 days after the myelogram so as to allow time for the dural opening from lumbar puncture during myelography to close. This will avoid contamination of the subarachnoid space with chymopapain at the time of chemonucleolysis.[10, 18]

Immunologic research suggests that pre-treatment with both H_1- and H_2- histamine receptor antagonists may help to decrease the severity of an anaphylactic reaction. For this reason, it is currently recommended that the patient undergoing CC be premedicated with diphenhydramine (Benadryl®) 50 mg po every 6 hours and with cimetadine (Tagamet®), 300 mg po every 6 hours for the 24 hours prior to injection.[16] While some authorities also recommend pretreatment with large doses of corticosteroids, this practice has never been shown to be effective. The patient is usually given at least a liter of balanced intravenous fluids immediately prior to the procedure so as to provide adequate hydration and to get a lead on balancing third space fluid loss should it occur with anaphylaxis.

Technique

CC should be performed in a hospital, usually in an operating room or radiologic suite. In addition to the qualified operating surgeon, it is recommended that an anesthesiologist and/or a physician skilled and experienced in the management of anaphylaxis should be in attendance. Assistance of nurses and an x-ray technologist is indispensable. A radiolucent table and a C-arm image intensifier are used for localization of needle positions in both the AP and lateral planes.

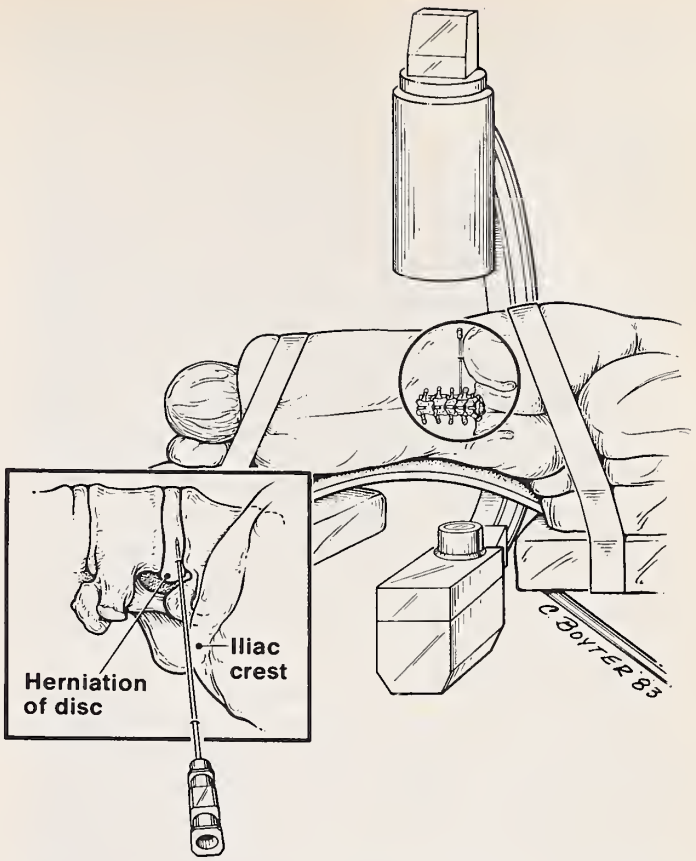


Figure 1 — Chymopapain chemonucleolysis is performed with the patient in the lateral decubitus position using C-arm image intensification to guide the needle into the proper lumbar intervertebral disc space.

Both general and local anesthesia have been employed successfully for CC.[3, 4, 10, 18] The advantages of general anesthesia include total anesthesia for the patient and the fact that the endotracheal tube is already in place enabling the anesthesiologist to respond rapidly in the unlikely event of an anaphylactic reaction. Local anesthesia, generously supplemented with tranquilizing and sedative agents as deemed necessary by the anesthesiologist in attendance, may enable earlier and easier recognition of impending anaphylaxis. Moreover, this spares the patient intubation and other potential complications of general anesthesia itself, and the conscious patient will certainly be able to inform the surgeon when the needle contacts a nerve root, a situation one obviously wants to avoid. Prior to beginning the procedure, a large bore (16 gauge) intravenous line should be started, and all agents necessary for treating anaphylaxis should be made ready drawn up in syringes for rapid administration. An emergency cart including a cardiac defibrillator should be in the room.

The patient is placed in the lateral decubitus position and is prepped and draped in a sterile fashion (Figure 1). A needle is placed into the symptomatic pathologic disc from a postero-lateral direction so as to avoid penetration of the thecal sac.[6] Most surgeons confirm localization of the needle tip intra-

discally by performing a discogram with the injection of a small amount of iothalamate meglumine (Conray 60) prior to the injection of the enzyme.[18] Though spillage of the contrast material into the epidural space is not a contraindication to enzyme injection, the rarely seen entrance of dye into the thecal sac would be a contraindication. Patient allergy to iodine containing contrast agents would make discography inadvisable, and under such circumstances, correct localization of the needle tip can be confirmed by the AP and lateral x-ray views or by use of a saline acceptance test (injection of a small amount of saline into the disc to ascertain that there is no obstruction to the injection). In most instances, proper positioning of the needle has not been a problem for the surgeon skilled in the technique. Anatomic variations of the lumbosacral spine or pelvis, however, can sometimes make proper positioning of the needle tip difficult.

Recommended enzyme dosage for CC is 2,000 to 4,000 units per disc, or a volume of injection of 1 to 2 ml. The drug is injected slowly, following which the needle is withdrawn. Surgical drapes are removed, and the patient is observed for appearance of a rash or a change in vital signs signalling anaphylaxis. The patient is observed for at least 30 minutes after the injection by the anesthesiologist and surgeon in attendance and for another 2 hours in the recovery room prior to being returned to his/her hospital room.

Complications and Risks

Anaphylactic shock is the most serious complication of CC. It occurs in slightly less than 1% of patients. Such a reaction is acute and may be life threatening. In a worldwide experience of over 40,000 cases in which Discase® was used, two deaths attributable to anaphylaxis were reported. In the carefully controlled and monitored clinical trials of Chymodiactin®, a 1% incidence of anaphylaxis was also observed. In this study, women had a greater incidence than men (2.5% vs 0.18%). The presence of an elevated sedimentation rate or the fact that the treatment occurred during the patient's menstrual cycle may have predisposed the female more so to this complication. There are no skin tests or laboratory tests to determine which patients will be susceptible to chymopapain anaphylaxis.[15, 16]

The onset of symptoms of anaphylaxis usually occurs within 30 minutes of the time of injection of the enzyme. The severity, onset, and type of symptoms may vary from patient to patient, but, in general, would include urticaria, angioneurotic edema, laryngeal edema and bronchospasm, severe hypotension or cardiac arrhythmia which may lead to cardiac arrest, and vomiting or diarrhea with a large amount of "third space" fluid into the gastrointestinal tract complicating the cardiovascular hypotension. Emergency treatment of anaphylaxis includes immediate administration of epinephrine, diphenhydramine, and hydrocortisone, immediate intubation and fluid administration, and cardiorespiratory resuscitation if necessary.[19]

Other side effects of treatment with chymopapain include transient bladder dysfunction requiring catheterization, mild sensitivity reactions in the form of rash or urticaria, increased neurologic deficit in the leg or foot, and an inflammatory discitis. All of these side effects are of low incidence.[7, 11, 17, 18]

TABLE 1 — Results of Chymopapain Chemonucleolysis in Selected Clinical Patient Series

Author (ref)	*Number of Patients*	*% Satisfactory Recovery*
Wiltse (18)	1200	75
Ford (2)	854	81
Javid (4)	124	73-81
Onofrio (10)	72	71
Parkinson (11)	33	80-90
McCulloch (8)	220	80
McCulloch (7)	1340	68
"Illinois" (15)	273	90
"Chymodiactin" (15)	108	73

Post-operative Care

It is common for the patient's radicular leg pain to improve within the first 24 to 48 hours after injection. However, back pain may be exacerbated for a time, and severe spasms of the paravertebral musculature which may require narcotic analgesia lasting up to 5 days may complicate the post-operative period. Patients who do not suffer from back spasms may ambulate the day after surgery. The average hospital stay for the patient undergoing CC is about 5 days.[4]

Once home, the patient should increase activity only as back and leg pain allow and should not undertake any activity that increases the pain. Mild anti-inflammatory agents such as aspirin or acetaminophen may help during the period of convalescence. Sedentary work is usually well-tolerated in 3 to 4 weeks, and work or play requiring strenuous physical activity is delayed somewhat longer.

Post-operative x-rays will show progressive narrowing of the injected disc space.

Results

A review of clinical series of well selected patients in the literature shows that one can expect a satisfactory recovery in approximately 80% of patients undergoing CC (Table 1). Wiltse reports that of those patients with a neurologic deficit prior to injection, 61% had a return of a previously absent ankle jerk, 84% regained muscle strength, and 77%

had return of sensation in a previously analgesic area.[18]

If patient selection for CC has been according to rigid criteria for herniated soft disc disease in the lumbar area, the most likely cause for failure of the procedure will be an extruded disc fragment (i.e., "free fragment"), in the spinal canal.[1, 11, 18] In these patients, the extruded disc fragment can be removed through a standard partial hemilaminectomy and diskectomy. Open surgery is not made more difficult by prior CC, and at surgery an empty disc space at the site of the previous injection is usually found.

Summary

The most frequently asked questions about chymopapain chemonucleolysis (CC) can be answered as follows:

1. *What is chymopapain?*

Chymopapain is an enzyme derived from the papaya plant which, when injected into an intervertebral disc results in dissolution of the nucleus pulposus.

2. *Which patients are candidates for chemonucleolysis?*

Ideal candidates for this procedure are patients who demonstrate symptoms of clear-cut soft lumbar disc protrusion with signs of nerve root compression and in whom conservative therapy has failed. Prior to chemonucleolysis, disc herniation should have been documented by standard diagnostic procedures such as myelography and/or CT scanning.

3. *What are the pros and cons of CC?*

In properly selected patients, CC is a good therapeutic option and results in cure of the disorder in about 80% of patients. CC avoids an open surgical procedure and may shorten both hospitalization and recovery time. However, CC is not an innocuous procedure. Its use is associated with a 1% incidence of anaphylaxis, which may result in death and transient post-injection rash, urticaria, bladder retention, and painful lumbar muscle spasms.

4. *How, where, and by whom is CC administered?*

CC can be performed by any qualified neurosurgeon or orthopedic surgeon who is familiar with the technique. It must be accomplished in a sterile hospital environment with anesthesiology personnel and/or physicians experienced in the treatment of anaphylaxis in attendance at the time of injection. Injections are best administered under supplemented local or general anesthesia using x-ray image intensification for proper localization of the needle.

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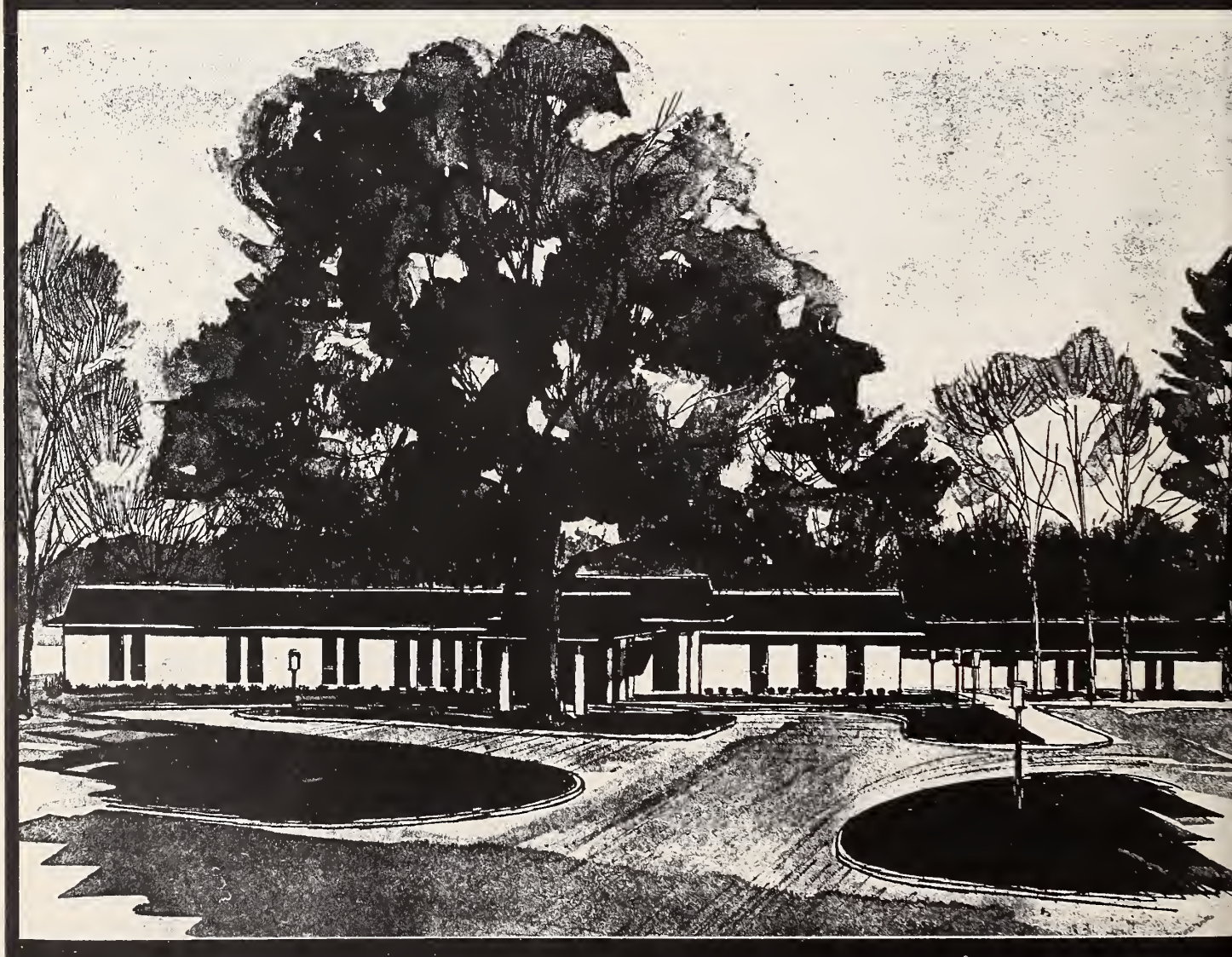
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The substitution of non-tobacco cigarettes may be attended by more immediate hazards than generally occur with tobacco cigarettes.

Carbon Monoxide Poisoning From Non-Tobacco Cigarettes

RALPH L. HAYNES, M.D., F.A.C.P., *Atlanta**

Introduction

THE CURRENT INTENSIVE interest in the hazards of tobacco smoking has greatly increased the numbers of smokers seeking to reduce or stop their dependency on this habit.[1, 2] The difficulties encountered by most smokers in this effort have provided a fertile field for clinics, programs, hypnotists, and the sale of products that reduce the quantity of inhaled tobacco combustants. One such alternative to tobacco smoking has been the development of non-tobacco cigarettes. These are advertised as alternatives for health-conscious smokers and are not required to carry the Surgeon General's warning label. It could be anticipated that untoward effects will follow the inhalation of any significant quantity of smoke, however, and it is presently premature to assume that non-tobacco cigarettes will prove less injurious to health than their predecessors.

A fortuitous observation in our laboratory has indicated that the substitution of non-tobacco cigarettes may be attended by more immediate hazards than generally occur with tobacco cigarettes, namely, carbon monoxide poisoning.

Case Report

A 55-year-old woman was admitted for elective lumbar intervertebral disk surgery. She had begun smoking tobacco some 30 years previously and averaged two packs of cigarettes daily. On the third hospital day, her husband confiscated her regular cigarettes and, in an effort to switch her to a more "healthy" product, supplied her with a non-tobacco substitute (Free; International Brands, Inc.; Los Gatos, Calif.). She consumed one pack (20 cigarettes) over the next 24 hours, and 1 hour after the last cigarette, had arterial blood drawn in the pulmonary function laboratory as part of routine testing. The PaO_2 was 64 mm Hg, the $PaCO_2$ 39 mm Hg, and the pH 7.45. The percent carboxyhemoglobin (COHb) was 28 (normal value, 0-2.3 percent); the oxygen saturation for hemoglobin (HbO_2) was 70 percent. A repeat value, obtained 30 minutes later, documented a COHb level of 24.2 percent. Physical examination demonstrated an irritable woman with complaints of cephalgia and weakness which had been attributed to a myelogram performed the previous day. Jugular pulsations were visible four centimeters above the clavicle with the neck at a 45 degree angle; sinus tachycardia and bibasilar rales were present. Mild nystagmus was appreciated in both fields of lateral gaze. No murmurs, gallops, or electrocardiographic abnormalities were detected. She was placed on 80 percent oxygen via face mask; sequential determinations for COHb at 4, 7, and 19 hours yielded values of 14.6, 4.6, and 0.7 percent, respectively. The above-noted abnormal physical findings were no longer demonstrable at 7 hours. To ascertain the patient's usual level of COHb with tobacco cigarettes, she agreed to smoke 20 cigarettes of her usual brand over a 24-hour period, as nearly as identical as possible to the Free product. Measurement of COHb prior to smoking with subsequent values at 30, 90, and 240 minutes after completion of the pack yielded levels of 1.9, 7.9, 6.1, and 4.9 percent, respectively.

Materials and Methods

To examine whether this patient's response to the non-tobacco cigarette was in some manner unrepre-

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This study was supported in part by a grant from the Trammell Foundation. This paper was prepared at the request of the Georgia Thoracic Society.

sentative, five experienced smoking volunteers (who smoked between one and two packs daily) were solicited from hospital personnel. Informed consent was obtained from each subject, and the study was approved by the clinical research review body of the hospital. Each individual was asked to smoke 20 tobacco cigarettes of his/her usual brand over a 12-hour period (or less) in his or her customary manner. Venous COHb determinations were made at 15, 60, and 180 minutes following completion of the last cigarette. The following morning, each subject was asked to smoke 20 non-tobacco cigarettes over the same period of time as was devoted to the tobacco product and venous COHb determinations were repeated. All COHb determinations were performed in triplicate on an IL 282 Co-oximeter (Instrumentation Laboratory, Inc., 113 Hartwell Ave., Lexington, MA 02173) and recorded by an IL 318 printer. The accuracy and precision of the instrumentation were maintained within 1 percent absolute and 0.5 percent, respectively, by standard techniques[3] and known standards (IL 282 Co-oximeter control and Cal Dye, Instrumentation Laboratory, Lexington, MA 02173).

The data were analyzed by paired t-tests. Values are expressed as mean ± one standard deviation.

Results

Table I presents the data for the 5 subjects (3 women and 2 men) and any symptoms that were volunteered. For each measurement period, the non-tobacco product achieved significantly higher COHb values than tobacco ($P < 0.02$); indeed, no individual in this small sample had lower COHb values with the tobacco substitute than with tobacco. The two men achieved worrisomely high COHb values of 17.6 and 16.5 percent, measured fifteen minutes after cessation of smoking. Smokers who had higher values for COHb with tobacco demonstrated that their habits of inhaling more smoke could produce striking elevations with the non-tobacco product.

Discussion

Tobacco smoking was referred to as "Preventable Public Health Enemy Number One" by the former Secretary of the Department of Health, Education and Welfare, Mr. Califano.[4] At present, approximately one-third of all adults still smoke and, overall, 9 of 10 current smokers have either tried to quit or would if they could find a means to do so.[1] Thus, an attractive market seems ready for exploitation by producers of alternatives to tobacco cigarettes.

The data presented here clearly indicate that increases in COHb levels, significantly above those observed with conventional cigarettes, attend the smoking of a new non-tobacco cigarette. The potential for CO poisoning by this product was illustrated by the index case; peak COHb levels were probably in excess of 30 percent. Although our 5 volunteer subjects did not achieve this extreme, it seems clear that substantially more CO is produced with this particular product than with conventional cigarettes. It is reasonable to expect that the rate of CO production should include the following variables: rapidity of inhalation, thickness of the combusting segment, porosity of the material about the combusting segment, and the material undergoing combustion. Thus, for tobacco, the type of cigarette seems to have little influence on the COHb level of smokers,[5, 6] probably reflecting the general uniformity of conventional cigarettes and stable smoking patterns among individual smokers. Non-tobacco cigarettes are composed of quite different materials; in the case of Free cigarettes, extracted butter fat oil from the cocoa bean was subjected to a flaking process, producing a dense material. Presumably, combustion is less complete and more CO is produced.

Carbon monoxide is a normal product of the catabolism of heme compounds and is produced in normal man at the rate of about 0.42 ml per hour.[7] Increases in production occur with higher metabolic rates. The blood of normal individuals, reflecting

TABLE 1 — Percent Carboxyhemoglobin Values in Venous Blood at Intervals After Smoking 20 Tobacco and 20 Non-Tobacco Cigarettes[1]

Subject	*Sex*	*Age*	*15 Minutes[2]*		*120 Minutes[2]*		*240 Minutes[2]*		*Comments Upon Completing Non-Tobacco Cigarettes*
			Tobacco	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	*Tobacco*	*Non-Tobacco*	
1. LH	M	42	9.0	17.6	7.0	12.7	5.5	9.2	Headache, sleepiness
2. LT	F	24	7.4	11.6	5.0	7.3	2.9	4.3	Hazy vision, nausea, sleepiness
3. BA	F	22	6.2	8.8	3.9	5.3	2.4	3.5	Light-headed
4. JS	F	24	6.6	10.9	3.9	7.3	2.7	4.6	Sleepy, nausea
5. AA	M	31	12.1	16.5	9.7	12.9	7.4	10.1	Vertigo
Mean			8.26	13.08	5.90	9.10	4.18	6.34	
S.D.			1.07	1.69	1.11	1.55	0.98	1.37	
		t		4.84		4.45		4.59	
		p		<0.01		<0.02		<0.02	

Legend: M = Male; F = Female.

[1]Free; International Brands, Inc.; Los Gatos, Calif.

[2] Time given is minutes after last cigarette.

this endogenous source and a variable environmental component, may contain 0-2.3 percent COHb.[8] Small quantities of exogenous CO, inhaled over time, may produce considerable elevations in COHb since CO has approximately 240 times the affinity for hemoglobin (Hb) as oxygen. The effect of CO is not merely that of rendering Hb incapable of carrying oxygen but also shifts the hemoglobin-oxygen disassociation curve leftward,[9] inhibiting the release of oxygen at the tissues. Since available oxygen becomes limited by reduced PO_2 at higher altitudes, a given quantity of CO will have increasingly severe effects and HbO_2 will thus be reduced accordingly, while CO uptake remains independent of barometric pressure.[10] Since CO is virtually completely carried in the blood as COHb, measurements of PaO_2 of plasma, as typically performed in routine laboratory analysis of arterial blood gases, may give normal values despite COHb levels in excess of 30 percent.[9] Furthermore, since the usual clinical laboratory provides HbO_2 on the basis of a nomogram relating this value to PaO_2 and pH, a normal and grossly erroneous HbO_2 value may be reported for blood containing excessive COHb. A measurement of COHb and HbO_2 saturation by a co-oximeter obviates these problems.

Symptoms from CO poisoning begin with values of 20 percent COHb and consist of mild, throbbing headaches. Levels in excess of 30 percent COHb are associated with headache, irritability and visual disturbances,[11] all of which our index case illustrated. Values above 50 percent frequently result in coma and death. Unconsciousness may occur without symptoms. Apthrop subjected normal men to steady state exercise and sufficient CO to raise the COHb to 30-50 percent and demonstrated no changes in respiratory frequency or minute ventilation. Since the carotid chemoreceptors are sensitive to PaO_2 and not HbO_2, hyperventilation is not a feature of CO poisoning.[12]

The median COHb for moderate cigarette smokers (less than two packs daily) is approximately 5.9 percent.[13] Our subjects had mean values of 8.26 ± 1.08 percent 15 minutes after smoking the last of 20 tobacco cigarettes. This value was 13.08 ± 1.69 percent with the non-tobacco product and remained significantly above the corresponding tobacco values at the 2 and 4 hour sampling periods. Both subjects with COHb values in excess of 16 percent complained of sleepiness, mild headache, and slight vertigo. Whether the reported side effects related to COHb, some presently unidentified additional toxin(s) of the cocoa bean extract, or some combination of these factors is unknown. Since exposed nonsmokers will develop elevations in COHb from sidestream smoke,[14] the hazards of this non-tobacco cigarette extends to those who willingly or unwillingly associate with such smokers.

It is thus possible to speculate that a critical set of circumstances could result in clinically important CO poisoning. For instance, if an anemic heavy smoker, who resides at higher altitudes and has underlying chronic obstructive lung disease with hypoxemia, were to inhale several packs of this cocoa bean product in a day, serious elevations in COHb and marked reductions in oxygen carrying capacity could result. Any of the consequences of CO poisoning could then follow.

In conclusion, a real potential for CO poisoning exists under certain circumstances with smokers of this new brand of non-tobacco cigarette. This problem may evade identification if routine arterial blood gases are relied upon for assessment. This study also suggests that substitutes for tobacco cigarettes can pose special, unforeseen hazards that will require clinical experience to identify. Despite the known hazards of tobacco smoking, it should be borne in mind that non-tobacco products could be even worse.

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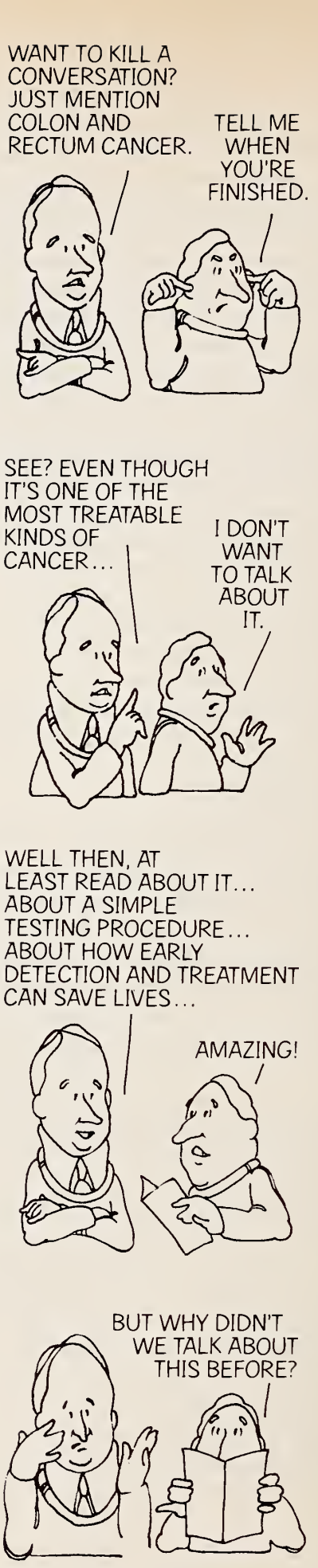
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Progress in the Treatment of Chronic Urinary Tract Infection — Malacoplakia: Current Concepts

PETER L. SCARDINO, M.D., and PAUL J. TILSON, M.D., *Savannah

WHILE SIGNIFICANT PROGRESS has been achieved in the diagnosis, understanding, and treatment of urinary tract infection by the classic investigations of Stamey,[1] Kunin,[2] and others,[3] certain problems persist.

An infrequent but often misdiagnosed associate of recurrent urinary tract infection is malacoplakia which, until recently, was a poorly understood inflammatory lesion usually confined to the urinary tract. The bladder is most often involved; however, reports of ureteral and renal parenchymal disease have also been observed. Middle-aged women are most commonly afflicted. *E. coli* is usually the offending organism. Ureteral or renal pelvic involvement may lead to the obstruction, hydronephrosis, and renal failure. Albeit rare, extraurinary tract involvement has been reported in the genital and gastrointestinal tracts, retroperitoneum, skin, adrenal glands, bone, and lungs.[4]

Case Reports

Case 1: A 27-year-old black woman presented to the Emergency Department with complaints of severe right flank pain and gross hematuria accompanied by fever, chills, nausea, vomiting, and dysuria of 1-day duration. History revealed carcinoma in situ of the cervix, diagnosed, and treated by cervical conization 1½ years previously. The patient specifically denied a history of urinary tract infection; however, close inspection of old records revealed six separate urine cultures positive for *E. coli* over the preceding 5 years. She had never been referred for urologic evaluation. There also was a history of quite heavy use of over-the-counter analgesics for chronic dull persistent pain in the right back and flank for several months.

Physical examination revealed temperature of 102 degrees Fahrenheit, suprapubic abdominal tenderness, and right CVA tenderness. Initial laboratory evaluation revealed moderate anemia, leukocytosis with a left shift, normal coagulation profile, pyuria, hematuria and bacteruria, BUN 29 and creatinine 2.2. Urine culture and blood culture both grew *E. coli*. Initial evaluation included an IVP demonstrating persistent nephrogram and very poor function of the right kidney consistent with obstruction or acute pyelonephritis (Figure 1). Distortion of the calyceal elements throughout the left kidney was noted with calyectasis of the upper pole collecting system and a suggestion of pooling of contrast material. Right retrograde pyelogram was unsuccessful due to the small caliber of the right ureteral orifice. Left retrograde pyelogram revealed no obstruction. Cystoscopically, multiple lesions were noted throughout the bladder which were submucosal mounds of variable size and yellowish coloration covered by erythematous mucosa.

Vigorous antibiotic therapy was begun. Right percutaneous nephrostomy was scheduled; however, administration of intravenous contrast material for localization of the right kidney revealed prompt and symmetrical excretion bilaterally without evidence of obstruction (Figure 2). Distortion of calyceal ele-

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Figure 1 Case 1, IVP no. 1.



Figure 2 Case 1, IVP no. 2.

ments throughout both kidneys was noted, with calyceal ectasia of the right lower pole and left upper pole as well as a suggestion of papillary necrosis. Rapid return of function of the right kidney, within 24 hours of initiation of antibiotics, suggested acute pyelonephritis. Cystoscopic bladder biopsy of the lesions revealed malacoplakia. After a full course of parenteral antibiotics, the patient was discharged on bethanechol chloride, ascorbic acid, and trimethoprim-sulfamethoxazole.

Case 2: A 33-year-old black female alcoholic, who denied any history of urinary tract infection, was found to have a urinary tract infection with *E. coli*. Microscopic pyuria and hematuria related to dysuria, urgency, and mild urgency incontinence. Physical examination relevant to the genitourinary system was unremarkable. Urinalysis, after a course of appropriate antimicrobial, continued to reveal TNTC WBC's, TNTC RBC's, but no bacteria. Urine cultures were sterile. Creatinine and BUN were normal. IVP and VCU revealed normal upper tracts and a markedly irregular bladder with numerous marginal filling defects (Figures 3 and 4). Cystoscopy revealed multiple elevated, broad-based, yellowish lesions distributed throughout the entire bladder. Biopsies of the lesions were obtained. Histologic examinations revealed large subepithelial aggregates of macrophages containing Michaelis-Gutman bodies and a benign transitional epithelium, consistent with malacoplakia (Figure 5). Bethanechol chloride, ascorbic acid, and sulfatrimethoprim were administered. She was discharged much improved.

Discussion

In 1977, Abdou[5] clarified the cellular deficiency that permits the development of what is described as malacoplakia, an uncommon, acquired, inflammatory granuloma. The disease is characterized by the collection of large mononuclear phagocytes with abundant cytoplasm, referred to as von Hanseman macrophages. These large cells contain characteristic inclusion bodies composed of lysosomal material called Michaelis-Gutman bodies. While usually confined to the urinary tract in association with chronic urinary tract infection, unclear systemic distribution may occur.

Electronmicroscopy reveals *E. coli* and *Klebsiella* in various stages of degradation in the phagocytic vacuoles of macrophages due, perhaps, to an intracellular defect of macrophages at the lysosomal level.

In the case studied by Abdou,[5] deficient monocyte bactericidal response to phagocytosed *E. coli* resulted in large intracytoplasmic lysosomal granules, poor lysosomal enzyme release after phagocytosis, and low levels of cyclic-GMP.

Further observations revealed the number of *E. coli* colonies growing in the presence of malacoplakia monocytes to be 5.7 times greater than that in the presence of cells from normal controls.



Figure 3 Case 2, IVP.



Figure 4 Case 2, cystogram.

In summary, Abdou found blood monocytes in malacoplakia to have the following defects:

1. A decrease in bactericidal activity to *E. coli*.
2. Abnormally large lysosomal granules.
3. Low levels of cyclic-GMP in the mononuclear cells.
4. Poor release of B-glucuronidase from leukocytes after exposure to opsonized zymosan particles.

The process of phagocytosis requires an intact internal framework of microtubules within the cell, as well as a functional network of contractile microfilaments. Cyclic-GMP stimulates the assembly of microtubules and a deficiency of cyclic-GMP impairs the integrity of the microtubular framework. The hexose monophosphate shunt is important in maintaining the proper redox state of the cell necessary for microtubular function and also in generating the power required by normal and active phagocyte function. It has been demonstrated by Oliver[6] and Sandler and associates[7] that cholinergic agonists stimulate an increase in the intracellular level of cyclic-GMP. Sandler and associates further showed the same effect with ascorbic acid. Ascorbic acid has also been shown to stimulate the hexose monophosphate shunt by Goetzl and associates[8] and Boxer and associates.[9] It was reported by Abdou and associates in their case that defective monocyte function was corrected by the administration of cholinergic agon-

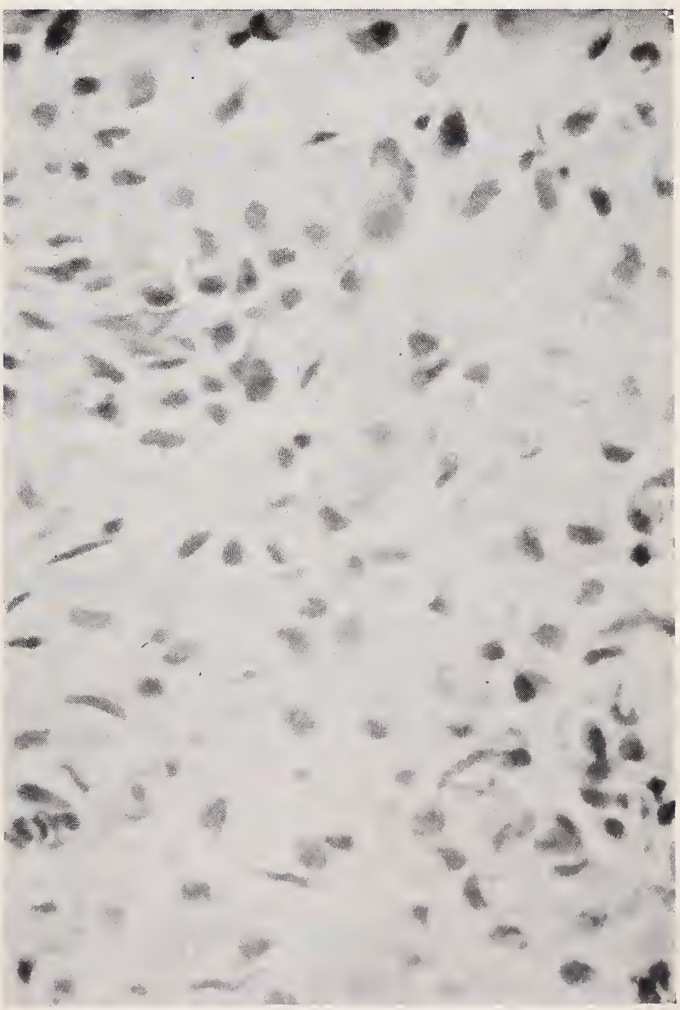


Figure 5 Case 2, photomicrograph of bladder biopsy.

ists. The successful treatment of malacoplakia of the urinary tract with cholinergic agents such as bethanechol chloride has been well documented.[10]

In summary, malacoplakia seems to result from an intracellular defect in phagocytosis and lysosomal degradation of bacteria due to low levels of cyclic-GMP in the macrophage. With this understanding in hand, effective treatment of malacoplakia is now possible using bethanechol chloride, ascorbic acid, and intracellularly active antibiotics.

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A statistical overview of the incidence of cancer in metropolitan and rural areas in Georgia.

Georgia Cancer Facts

MARGARET A. CHILD, M.D., M.P.H., and MICHAEL J. LYNN, M.S., *Atlanta**

The Atlanta Cancer Surveillance Center has 7 years of cancer data in its files for metropolitan Atlanta.** These cases were diagnosed from 1975 through 1981. In addition, the Center has a 4-year compilation from a 10-county rural area† between Atlanta and Savannah. These cases were diagnosed from 1978 through 1981. The number of invasive malignancies has increased from 4044 cases diagnosed in residents of the five-county metropolitan area in 1975 to 4750 in 1981. Part is due to the increase in population (11.6%), part to the increasing age-specific rates, and part to the higher proportion of older people in the population whose rates are higher. The number of *in situ* cancers has decreased from 770 to less than 600 during the same period. The proportion of cancer patients over 65 years has increased from 43% in 1975 to about 47% in 1981. This is even more striking in the rural area, where the proportion of cancer patients over 65 has increased from 52% in 1978 to 61% in 1981. The proportion of cancers in persons under 20 in both areas is about 1.6% and has not varied in the past 7 years.

TABLE 1 — Race and Sex Distribution

	White		*Black*	
	Males	*Females*	*Males*	*Females*
Metro Atlanta (1975-81)				
Number	11407	12549	3473	3147
Percent	37	41	11	10
Rural Georgia (1978-81)				
Number	385	325	268	221
Percent	33	27	22	18

TABLE 2 — Race and Age Distribution

	Atlanta		*Rural*	
	White	*Black*	*White*	*Black*
Percent in 1980 Population	71	27	48	52
Percent of Total Cancers	78	22	59	41
Percent over 65	8	6	16	11

Race and Sex

In the metropolitan Atlanta area, there are more cancers in white females than in white males. In the rural area, the larger proportion is in white males. For both areas, there are more cancers in black males than in black females. These differences are shown in Table 1.

Relative to the proportion of whites and blacks in the population, there is a higher proportion of cancers in whites than blacks, probably because they live longer. This is reflected in the higher proportion in the over-65 group (Table 2).

Source

Most cancer patients are identified by examining hospital inpatient records. A few are identified from private pathology laboratories and from physicians' offices; about 40 per year are unexpected findings at autopsy; about 50 per year, found on death certificates, have been untraceable back to a hospital or physician. These latter are tallied as if diagnosed during the year of death. The distribution is shown in Table 3.

* Dr. Child is the Director of and Mr. Lynn is the Statistician of the Atlanta Cancer Surveillance Center, 246 Sycamore St., Decatur, Georgia 30030. Send reprint requests to Dr. Child.

** Fulton, DeKalb, Cobb, Gwinnett, and Clayton counties.

† Glascock, Greene, Hancock, Jasper, Jefferson, Morgan, Putnam, Taliaferro, Warren, and Washington counties.

TABLE 3 — Source of Data

	Number	*Percent*
Hospital	29991	96.5
Private path labs	146	0.5
Private physician	288	0.9
Autopsy only	273	0.9
Death certificate only	367	1.2

Residence

Thirty-five percent of the population of metropolitan Atlanta live in Fulton County, but 44% of all the cancers are diagnosed in Fulton County residents. We believe this is because it has the highest proportion of older persons. The proportions by county are shown in Table 4.

TABLE 4 — Age and County of Residence

	Fulton	*DeKalb*	*Cobb*	*Gwinnett*	*Clayton*
Percent of total 1980 population	35	29	18	10	9
Percent of total cancers	44	28	15	7	7
Percent over 65 years	10	7	6	5	4

Multiple Cancers

Of the 31,072 invasive cancers in our Registry for the metropolitan area, 27,273 (88%) were first and only cancers. Four percent are the first of more than one primary cancer, and 12% are a second or higher. There are more "seconds" than "firsts" because many "firsts" were diagnosed before 1975 and are therefore not in our file. Three persons had at least eight separate primary cancers.

Laterality

Sixty-two percent of cancers were primary in a single (not paired) organ. Thirty-four percent originated in one of a pair such as breast or kidney. More than half (52%) were in the right organ.

Diagnostic Confirmation

There was microscopic confirmation in 93.9% of cases (Table 5).

TABLE 5 — Method of Diagnosis

Positive histology	91.4%
Exfoliative cytology	2.5%
Visualization (no micro)	0.6%
Radiologic only	2.7%
Clinical only	0.7%
Unspecified	2.9%

Therapy

SEER rules require that only the first course of treatment be recorded. A subsequent course following the failure of the first or that for a recurrence is not recorded. Therapy is defined as destruction or removal of proliferating malignant cells (excluding incisional biopsies) even though this might not have been considered curative. Palliative treatment (not removing cancer tissue, such as a colostomy) is not recorded as therapy; neither is an exploratory operation. Included are all modalities of treatment received within the first 4 months following initiation of therapy. It may begin at any time.

Using this definition of therapy, 83% of patients received some therapy. Sixty-one percent had surgical resection; 31% had radiotherapy; 19% had chemotherapy; 5% had some sort of hormonal therapy; less than 1% received immunotherapy or some other treatment. These percentages varied little between the years 1975 to 1981.

Of the 9684 patients having radiotherapy, 86% were known to have had beam therapy, 11% had "other." Of the 4350 patients having radiotherapy with surgery, 1% had it both before and after their resection, 18% had it before only, and 75% had it only after resection. The sequence of the others was unknown.

Follow-up Status

One of our tasks is the annual follow-up of our approximately 20,000 living patients. It has been calculated that it takes about 10 years for the number of alive patients to become constant. By then, the number of patients newly diagnosed and added to the file in 1 year about equals those dying who were diagnosed in previous years. We are approaching this equilibrium, as 36% of patients diagnosed in 1975 are alive, while 35% of patients diagnosed in 1981 are dead.

The Atlanta SEER had the highest overall follow-up rate of all the SEER registries in 1982, 91% for patients diagnosed between 1975 and 1981. We thank the tumor registrars and all the cooperative physicians who make this possible.

The Atlanta Cancer Surveillance Center will be continuing to collect Georgia cancer data. With the acquisition of 1980 census data tapes, more accurate determination of rates will be possible. Most welcome will be the possibility of analyzing black/white differences.

Dr. Quattlebaum has contributed much to the medical community in his more than 60 years of practicing.

Dean of Savannah's Medical Community Wins Acclaim For His Life's Work

EVELYN WARD GAY, ***Decatur****



Julian K. Quattlebaum, M.D.

THE SPRING OF 1983 was a very special time for Dr. Julian K. Quattlebaum, the man who is called the "dean of Savannah's medical community." Within a few weeks, he saw his 1957 book, *The Great Savannah Races,* reissued by his alma mater, The University of Georgia, and became the recipient of the Medical College of Georgia's first Distinguished Alumnus Award, denoting "a life of distinction, eminence, and excellence." The award was presented at the medical college's annual Honors Day on April 14, 1983.

In selecting Dr. Quattlebaum for this honor, a medical school spokesman said of him, "He's our all-time greatest alumnus." Alumni Association president, Dr. LaMar S. McGinnis, Jr., wrote him the group's thanks for "the outstanding example you have set for coming generations to follow."

Dr. Quattlebaum, 87 years of age in July, practiced surgery in Savannah for almost 60 years before his recent retirement, and he has many memories of "how it used to be." In an interview at his home in Savannah recently, he talked about his early experiences in both sports and medicine.

Born and reared in Statesboro, the son of a country doctor, he received his college education at the University of Georgia in Athens where he was graduated in 1917. He recalls that his first year there cost a total of $383. In September of 1914, he became manager of the Sigma Chi fraternity house, and was able to pay his expenses for the next 3 years.

But his college life had not been all roses at the beginning. He remembers well his struggles to please a math instructor, who made him feel "stupid" until he was rescued by another teacher who gave him confidence in himself. He was interested in writing, he says, and studied the short story and took other courses in English, which he enjoyed very much. Although he made a "C" in the short story writing course, he has continued his love for writing and has plans to compile his own book of short stories when he has the time. He also has satisfied his desire to write by contributing many articles to the medical literature and to the medical history of his state. And in spite of his early difficulties in getting adjusted to his college studies, he ended up making the dean's list.

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Send reprint requests to her at 911 Vistavia Circle, Decatur, Georgia 30033.

Students for medical training had to be recruited in 1917, he explains, and he actually did not know that he had been accepted to study at the Medical College of Georgia until the day before he was to report. Before traveling from Statesboro to Augusta by train, he had to hustle about and borrow $200 to get started. In making a loan for that amount, collateral was necessary, and he was required to take out an insurance policy that cost him $30 a year. Each summer thereafter he played semi-professional baseball and borrowed more money to get along. His diligence in spending many extra hours in the dissecting laboratory and at his studies gained him an "A" in anatomy and the distinction of being at the head of his class for 3 years.

Following his graduation from medical school in 1921, Dr. Quattlebaum settled in Savannah — not by choice but "entirely by accident," he admits. The way he tells it, he was on his way to a hospital in New York when he received a call from some friends in Savannah, with whom he had played baseball over the years, asking him to come and play shortstop in a game between two of the four teams comprising Savannah's City League. He did so well in that game that he found it "utterly impossible to leave Savannah" and was persuaded to accept a job at the old Savannah Hospital, later to become the Candler Hospital. He was told by Dr. Lawrence Lee, Sr., chief physician there at the time, that he could play baseball three times a week so long as he kept up his duties as an intern. At the old Savannah Hospital he received $50 a month, out of which he was able to pay off some of his indebtedness and the premium on his insurance policy, which he still has.

The second year he was in Savannah he began working with the late Dr. T. P. Waring, Sr., a surgeon and obstetrician, who became his advisor and benefactor. In 1922 he began his surgical practice in Savannah, doing much of his work at the Oglethorpe Sanitorium, which was closed in 1970. During the coming years, he visited the leading medical centers in the country, including Johns Hopkins and the Mayo Clinic, to serve apprenticeships. He has a photographic memory, he says, and was able to see and repeat many of the difficult operations he witnessed.

In his early years in Savannah, he served on the first State Board of Vocational Rehabilitation, an appointment growing out of his interest in the handicapped which came about because he had a brother who was "90% blind." During those years, he says, he also developed his lasting philosophy of "taking care of one's parents." His father, Dr. A. W. Quattlebaum, a graduate of the University of Maryland, suffered a stroke and lived 3½ years. It fell his duty to care for his parents during his father's last years. His mother also was ill, and he took care of her for 40 years after his father's death.

Dr. Quattlebaum has taken an active part in organized medicine all of his professional life. He joined the Georgia Medical Society and the Medical Association of Georgia in 1922, and has written many articles for *The Journal of the MAG*. In 1928, he became a Fellow of the American College of Surgeons. To do so, he had to submit reports of 50 major operations he had performed, 50 at which he had assisted or performed, in addition to the required recommendations from current members.

In 1951, he was inducted into the Southern Surgical Association as the first person to be admitted without formal training, and served a 1-year term as first vice president of that organization. He was a charter member of the Southeastern Surgical Congress, and in 1960 he helped to organize the Georgia Surgical Society. As the first chief of surgery at Memorial Hospital, he lectured to students and always told them to buy and read Garrison's *History of Medicine* which contains Ambroise Paré's words, "I treat 'em, God heals 'em!" After the organization of the Georgia Surgical Society, he designed the certificate for that group based on the life of Paré (1510-1590) who "rose from the humblest roots of a barber-surgeon to become one of the 3 greatest surgeons of all times," and who rediscovered the use of the ligature for the control of hemorrhage.

In 1981, Dr. Quattlebaum was given the MAG's Hardman Cup in recognition of original contributions to surgery. In the 1950s, he had developed a surgical technique in excisional therapy for liver tumors, a report of which, "Massive Resection of the Liver," appeared in the *Annals of Surgery* in May of 1953. He also had rediscovered the use of the ligature for the control of bleeding. Several other articles followed in the same journal, as well as in other major medical publications.

Dr. Quattlebaum attributes any successes he has enjoyed to what he terms "the one talent God has given me — work." He considers *work* as Osler did — "The master word of medicine."

With his medical background, how did he ever get involved in automobile racing? He explains that he and the automobile came along "at about the same time," and by the time he grew up his father had bought a 1909 white Buick. Since his father never learned to drive it, he was allowed to act as chauffeur on trips all over the county. He was fascinated by automobiles, and in 1910-1911 went to Savannah to see the contests between some of the greatest drivers of all times. "That was a thrill," he exclaims, "and I wouldn't take anything for those days." There were no tracks at that time, he says, and the races usually took place on links of the best roads available. In Savannah, the first grandstands had been set up on Victory Drive at Habersham and Lincoln

Streets, and on Waters Avenue in 1910-1911.

In 1957, his book, *The Great Savannah Races of 1908, 1910, and 1911,* was published by the R. L. Bryan Company, of Columbia, S. C. He wrote it, he says, to preserve a very important bit of local history. In 1960 he found a white 1909 Buick in Michigan and bought it. It was the same model he had driven as a boy of 13. He acquired two other old cars, a 1911 Buick and a 1913 Buick, in the next several years, but has since sold them to a museum in Savannah. In the late 1960s, he helped to organize the Savannah Chapter of the Antique Automobile Club of America. In May of 1983, the University of Georgia Press reissued his book, *The Great Savannah Races,* with a new introduction and many new photographs.

On June 21, 1983, Dr. Quattlebaum and his wife, the former Helen Burkhalter, celebrated their 59th wedding anniversary. They are the parents of three children. The son, Julian, Jr., who received his medical training at Johns Hopkins, is a surgeon in Savannah. One daughter, Helen Artley, is married to the president of the Artley Construction Company, founded in 1901, which was responsible for building the stands for one of the early automobile races. The other daughter is Barbara Parr, whose husband W. H. Parr is employed in personnel with the Georgia Bar Association. The Quattlebaums have 13 grandchildren and three great grandchildren, none of whom has yet shown an interest in medicine.

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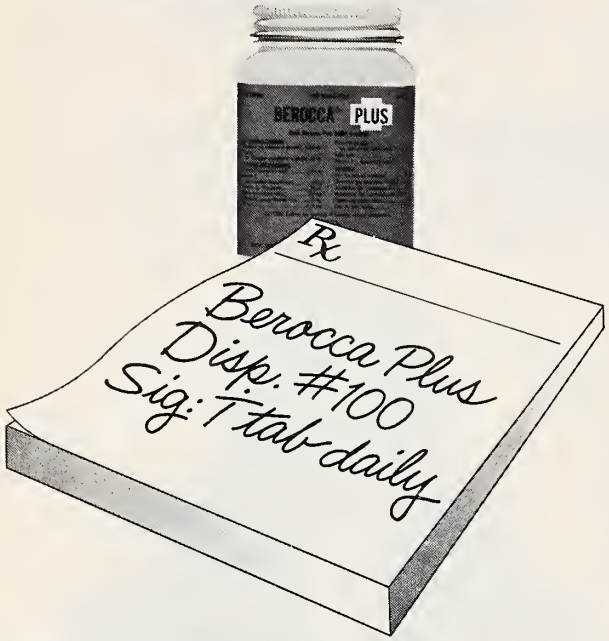
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Who Is To Control Our Fees?

REPORT "D" of the *A.M.A. Council on Medical Service* is included in this issue of the *Journal* [on page 567]. The timeliness and importance of this report for Georgia physicians is extraordinary in view of the current Atlanta Blue Shield Plan proposal for a *Participating Physicians Program*. The Council is one of seven A.M.A. committees and is charged to study and evaluate the social and economic aspects of medical care. Serious and detailed evaluation of payment mechanisms for both physicians and hospitals has been a major part of the Council's work.

In Report "D," the Council gives a careful synopsis of A.M.A. policy regarding payment for physician services. Specifically, continued support of the *UCR* (usual, customary, and reasonable) payment mechanism is contrasted with a change to an *Indemnity Based System* for all third party payments for physician services. This change would involve the insurance company setting its allowances for a particular physician service which could have little or no relation to the fee charged by the physician. Both the patient and physician would be aware of this payment amount and both would be aware of the patient's responsibility to pay the balance of the physician's charges.

The Council believes that adoption of this *Indemnity Based System* will assure the physician greater freedom from control by insurance companies which are developing *Participating Physicians Programs*. It is felt that eventually physicians' remuneration could be determined solely by third party payers for the great majority, if not all, of the professional services they render — with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

The Atlanta Blue Shield Plan sees their *Plan* as an opportunity to control costs and offer subscribers the provision of covered physician services at *no* additional cost to the patient, in the case of 100% *UCR* plans. For those plans covering a percentage of *UCR*, the insured patient would be responsible only for the unpaid percentage of *UCR* as determined by the Atlanta Blue Shield.

Lists of participating physicians are to be provided all subscribers to the Atlanta Blue Shield, and decals will be provided for participating physicians to let their patients know they have agreed to the plan. Subscribers who utilize non-participating physicians will receive payment themselves for covered services instead of having the payment sent directly to the physician who provided the service.

I urge every physician in the state to read Report "D" *very carefully — word for word* — and seriously consider the implications of its message. The A.M.A. House of Delegates will be debating this issue at the Interim Meeting in December and, in addition, you will have to decide whether or not to become a participating physician in the Atlanta Blue Shield Plan by January 1, 1984. Contact your A.M.A. Delegate with your views.

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Nursing Care in the Management of the Maxillectomy Patient

MICHAEL A. CARPENTER, D.D.S., and
BARBARA A. CARPENTER, C.D.A., *Decatur**

KNOWLEDGEABLE NURSING CARE can diminish morbidity and improve recovery during the hospital experience of patients who have undergone ablative cancer surgery of their maxilla. A maxillectomy is the removal of a portion or all of the maxilla.[1] A more extensive resection is performed should the cancer involve the orbit, cheek, or surrounding structures. This type of surgery alters the patient's anatomy and physiology that affects speech and deglutition.

During the patient's hospital stay, the nursing staff is in close daily contact with him and is in an excellent position to provide the care and assistance he needs, as prescribed. It is essential that the nurse be aware of the patient's physical and emotional state of mind as related to the patient's maxillary cancer.

The three basic stages that the nursing staff needs to address during the patient's hospital stay are (1) immediate post-surgical recovery, being the first 1-3 days in which the patient is in ICU; (2) the first week out of ICU and adjusting or adapting to their loss; and (3) having the surgical packing removed and getting ready to leave the hospital.

The nurse needs to be able to help the patient cope with his tumor prognosis and morbidity during the immediate post-surgical recovery. She or he needs to be aware of complications and have an open line of communication between the patient about his concerns, questions and fears now and throughout his hospital stay.

During the immediate post-surgical recovery, the patient may have a tracheotomy and a naso-gastric tube. He should be informed that there is suction next to him, should he need it. He may have a surgical prosthesis that has been inserted at the time of surgery to cover the surgical defect and aid in holding sterile packing in place. He will be mouth breathing due to the packing in the nasal sinus area. This will cause the patient to have dry mucous membranes, mouth ulcerations, and an increased cariogenic potential. The nurse can comfort the patient during this early recovery stage by applying a neosporin ointment to his lips, which are usually dry and cracked, and by keeping the patient's mouth moist with artificial saliva or ice chips if allowed in ICU.

Once the patient is removed from the ICU, the nurse can initiate oral hygiene care, usually within 48-72 hours post-operatively. The oral cavity needs to be cleansed of dried, crusted blood and dried mucous secretions on the teeth, tongue, and gums. This can be done by using toothettes, a soft toothbrush, or a hemostat and gauze with water and peroxide, suctioning as needed. The nurse may offer the

* Dr. Carpenter is a maxillofacial prosthodontist and Chairman of the Georgia Section, American College of Prosthodontists; Ms. Carpenter is a certified dental assistant. Send reprint requests to Dr. Carpenter at 1924 Clairmont Rd., Decatur, Georgia 30033.

Prepared at the request of the Georgia Division, American Cancer Society.

patient ice chips to help moisten the dry mouth, and the patient can then attempt to swallow the melted ice to help him maintain the swallowing reflex.

The maxillofacial prosthodontist should have written specific dental orders in the patient's chart as related to the oral care following maxillectomy. These specific instructions may include: brushing techniques, using a baking soda-water-peroxide toothpaste, dental flossing wherever possible, oral irrigation to the remaining teeth and sodium bicarbonate mouth rinses, use of moist gauzes, toothettes or lemon swabs, jaw exercises and initial instructions on using the prosthesis for speech and swallowing, and the care and use of the patient's dentures. Once he is ambulatory, the nurse can help the patient initiate the care of his oral hygiene, being careful to observe that he is not too vigorous to cause trauma to the surgical wound. Performing the above mentioned specific written dental orders will help to keep the oral bacterial count down, and the patient will be more comfortable and healing time may be decreased. His psychologic outlook may thus be improved. The reinforcement of performing jaw exercises is to maintain maximum mobility and opening of the jaws.

During this second stage, the patient may be told he will have further therapy for his cancer. The nurse can talk with the patient and help him understand the specific effects of the therapy he will be given. Specific effects of chemotherapy are: mucositis, ulcerations, possible xerostomia, jaw pain, and the possibility of infection due to a depressed immunosuppressive response in the patient.[2] The side effects of radiation can be: xerostomia, mucositis, fibrosis, trismus, radiation dermatitis, radiation caries, soft tissue necrosis, and osteoradionecrosis.[3]

Throughout all three stages, the nurse should be able to relate to the primary health care professionals caring for the patient and inform them on how the patient is progressing.

The final stage is usually 10-14 days post-surgically, when the surgical packing is usually removed. The patient may have a surgical prosthesis, and he may sense that the prosthesis may or may not be stable after the packing is removed. The prosthesis may even over obturate the defect. This all depends on the surgeon, his excision, and the extent of the surgery. The prosthesis cannot be altered greatly at this time, as initial healing is taking place and the mouth is still quite sore. The patient will be able to breathe out of his nose now that the packing is removed, and the nurse should instruct the patient to do so, to decrease oral dryness and its sequelae. When the patient attempts to swallow food or liquids at this time, the fluid may come out of his nose. It will be beneficial to take small sips or amounts of food and have the patient tip his head back slightly when swallowing. Even though the naso-gastric tube is in place, the swallowing reflex should be encouraged by first swallowing water or melted ice chips, then diced foods. The patient should be reassured that these conditions may be improved upon by an eventual definitive prosthesis, which will enable him to speak and swallow better.

Before the patient leaves the hospital, the nurse will inform the patient of homecare instructions as prescribed by the doctor(s) caring for the patient. Sometimes these instructions need to be explained to a family member or close friend. The nurse will reinforce the need for activity, comfort, nutrition, continued excellent oral hygiene, and jaw exercises.

The nursing staff is one of the most important auxiliaries the patient will have caring for him while in the hospital. She or he will care for the patient's physical and emotional well being, help initiate and maintain good oral health, be aware of oral manifestations taking place post-surgically, help educate the patient regarding effects of cancer therapy, discuss nutritional aspects of his diet post-operatively, and prior to leaving the hospital, monitor his vital signs and medication, and relate to the primary health care professionals the patient's progress.

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3. Beumer J, Curtis TA, Firtell DM. Maxillofacial Rehabilitation. St. Louis, 1979, The C. V. Mosby Company, p 23-25.

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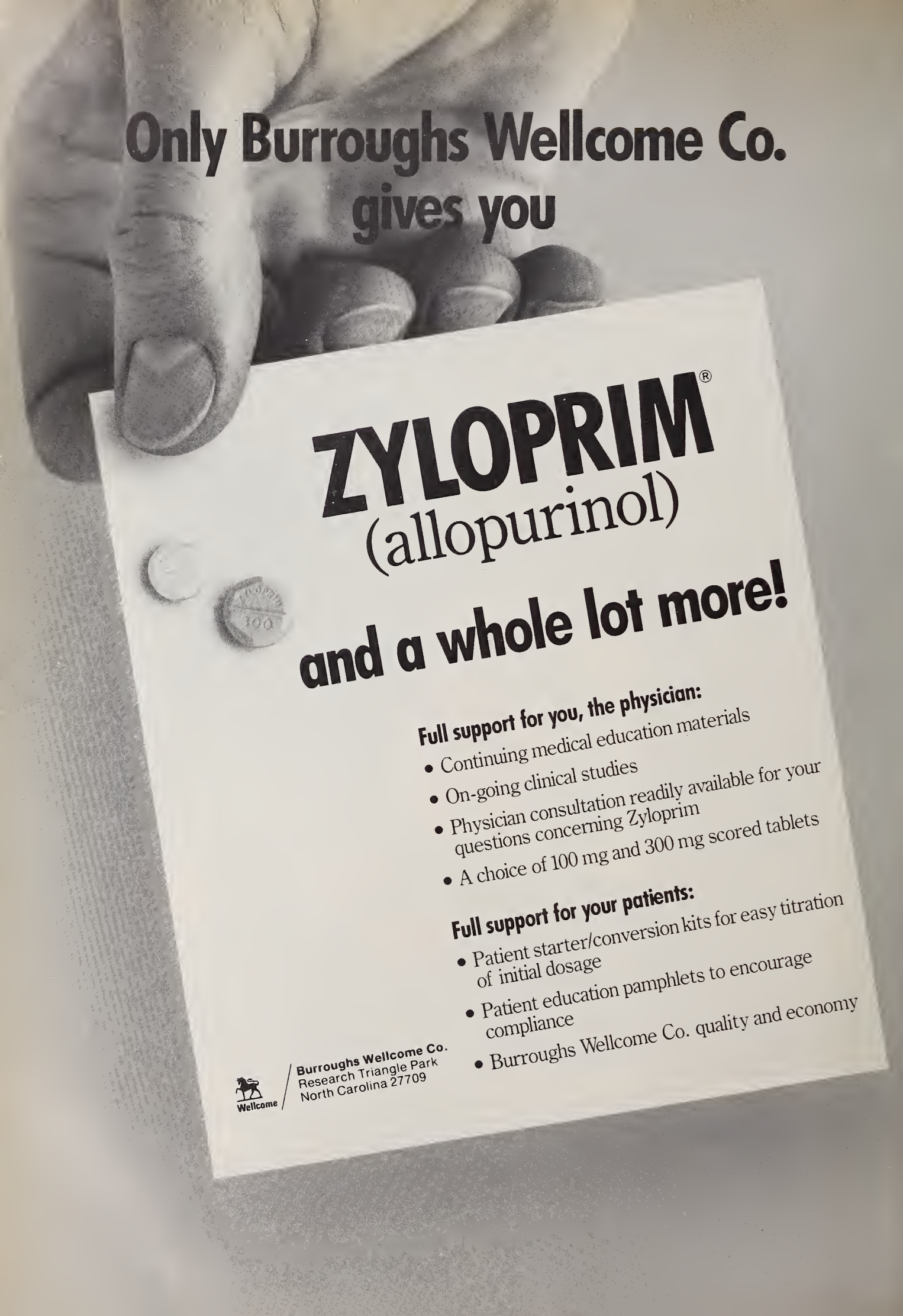
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Applying the Antitrust Laws to Exclusive Arrangements for the Provision of Hospital-Based Medical Services: A Tale of Two Hospitals

ROBERT N. BERG, *Atlanta**

Prior to 1975, it was thought that "professionals" such as physicians, attorneys, architects, and engineers were beyond the reach of the federal antitrust laws. As a result, the activities of professionals historically were structured without consideration of the possibility that the anticompetitive consequences of those activities could expose the professionals to liability. In 1975, however, the United States Supreme Court leveled the "learned profession" exemption by holding that professionals were subject to antitrust regulation,[1] thereby opening the door for a seemingly endless array of antitrust challenges to the activities of professionals. Consequently, all professionals — including specifically health care practitioners and institutions — have been forced to reassess from an antitrust perspective, and in many instances revise, the types of activities which they provide and the manner in which those activities are provided.

An example of this reassessment process can be found in the area of exclusive arrangements between hospitals and physicians for the provision of hospital-based medical services. Historically, hospitals have entered into exclusive contracts with a number of different types of practitioners, including anesthesiologists, radiologists, and pathologists. Similarly, hospitals have used the concept of a "closed staff" in connection with the provision of emergency services. Foremost among the justifications for these exclusive arrangements was the fact that an exclusive contract allowed the hospital most efficiently and economically to utilize its finite resources and assure the availability of particular services, thereby improving the overall quality of patient care at the institution.

Until recently, justifications such as this were sufficient for hospitals to thwart antitrust challenges to exclusive arrangements. However, a recent decision by the United States Court of Appeals for the Fifth Circuit holding that an exclusive contract between a hospital and an anesthesiology group violated the antitrust laws — decided less than 2 months after a different Court of Appeals had upheld the validity under the antitrust laws of the same type of arrangement — has forced hospitals and physicians to consider modifying their contractual relations. A review of these two recent cases provides some interesting insight into the problems inherent in applying the antitrust laws to the health care profession.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

General Antitrust Principles

First, a short refresher course in basic antitrust laws and analysis is appropriate. The primary "federal antitrust laws," the Sherman Act and the Clayton Act, both generally prohibit activities in restraint of trade. Among these prohibited activities are "exclusive dealing arrangements," defined as the selling or leasing of goods or the providing of services *only* upon the condition that the purchaser refrain from purchasing the goods or using the services of the seller's competitors, and "tying arrangements," defined as the selling of one product (the "tying product") *only* on the condition that a second product (the "tied product") also is purchased. If the arrangement involves the sale of goods, it usually is analyzed under Section 3 of the Clayton Act;[2] if it involves the provision of services, the relevant statute is Section 1 of the Sherman Act.[3] In either case, however, the antitrust analysis used by the courts is essentially the same.

In order to determine whether or not a particular exclusive arrangement constitutes unlawful "exclusive dealing" or an unlawful "tying arrangement," the court will undertake one of two analyses. In most cases, the court will use what is known as the "Rule of Reason," which involves a full-blown analysis of the pro-competitive and anticompetitive aspects of the arrangement, together with the justifications offered by the parties to that arrangement. Only if the exclusive arrangement, on balance, is anticompetitive will it be found to constitute an unreasonable restraint of trade.

In certain instances, however, courts have determined that certain types of activities, because of their highly destructive effect on competition, should be found unlawful without an elaborate inquiry into the specific competitive effects or justifications. As to these activities (the best example of which is price-fixing), courts use what is known as a "*per se*" analysis, which, in effect, presumes that the arrangement constitutes an unreasonable restraint of trade. Accordingly, a plaintiff in a *per se* case, to be successful, need only establish the existence of the unlawful arrangement itself (e.g., a contract or agreement to fix prices), without having to go further and prove the specific anticompetitive effect. More importantly, in a *per se* case, the defendants are not allowed to justify the arrangement on the basis of good intentions or the fact that the arrangement in actuality results in pro-competitive effects.

With these basic antitrust principles in mind, we then turn to the two cases dealing with the validity under the antitrust laws of exclusive contracts for the provision of anesthesiology services.

Exclusive Anesthesiologists' Contracts Are Lawful in the Seventh Circuit . . .

In *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center,* the facts before the Court were relatively simple: the plaintiff was a former employee of an anesthesiology group which had entered into an exclusive contract with a hospital. When the plaintiff's staff privileges at the hospital were reduced from active to courtesy staff, her employment with the anesthesiology group was terminated. Subsequently, the hospital — based upon its exclusive contract with the physician's former employer, the anesthesiology group — informed her that she would no longer be permitted to offer anesthesia services at the hospital.

The plaintiff filed an action against the hospital and the anesthesiology group, claiming that the exclusive arrangement constituted unlawful "exclusive dealing" in violation of the Sherman Act; she also filed a motion for a preliminary injunction in order to force the hospital to allow her to provide anesthesiology services. Following a hearing, the District Court granted the plaintiff's motion and enjoined the enforcement of the exclusive contract, holding that the exclusive contract unreasonably restrained competition and that the physician-plaintiff would be irreparably injured (e.g., loss of salary, damage to reputation, etc.) if her staff privileges were not reinstated pending a trial.

On appeal, the Seventh Circuit reversed the District Court's decision, finding that the plaintiff had failed to establish the necessary elements in order for a court to grant a preliminary injunction. With respect to the antitrust aspect of its analysis — whether the physician had established a reasonable likelihood of succeeding on the merits in her antitrust challenge — the Court commenced by finding that the arrangement between the hospital and the anesthesiology group was a "vertical" combination (i.e., an arrangement between persons or entities at different functional levels, undertaken for the purpose of integration, rather than a "horizontal" arrangement between competitors at the same functional level). Therefore, the arrangement must be analyzed under the Rule of Reason, an analysis described by the Court as involving a determination of:

> " . . . whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. . . . In the context of exclusive dealing arrangements, this means that the plaintiff can prevail only by showing that the agreement in question results in a substantial foreclosure of competition in an area of effective competition, that is, in a relevant market."[5]

Using this analysis, the Seventh Circuit also took issue with the District Court's conclusion that the exclusive contract was an unreasonable restraint of trade. In the District Court's view, the relative market was the "competing providers of anesthesia services at [the defendant] Hospital;" in that market, the anesthesiology group, comprised of the only anesthesiologists who could provide services at the hospital, had a virtual monopoly, "leaving [the anesthesiology group] free to set prices and to determine the quality of services without competitive pressures."

The Seventh Circuit disagreed, expressing significant "doubt whether the relevant market can be sliced so small as to embrace only a single hospital."[6] Rather, the Seventh Circuit suggested that it may be the hospitals, not the individual patients, which are the real purchasers of anesthesia services, a fact which would require a relevant market definition consisting of the area in which the defendant anesthesiology group operated and in which the hospital (rather than the patient) could practicably turn for the provision of anesthesia services by other anesthesiology groups. As stated by the Court:

> "Because the patient generally takes no part in the selection of a particular anesthesiologist . . . and because the expense of anesthesia services to the patient is ordinarily at least partially insured or otherwise payable by a third party, it might be somewhat anomalous to treat the patient as a buyer. The patient in these circumstances receives the service but does so without making any significant economic decision. It may thus be more appropriate for antitrust purposes to treat the *hospital* as the purchaser, in view of the hospital's responsibility for assuring the availability of anesthesia services for its patients, its incentive to maximize the use of its surgical facilities and its potential liability for negligent rendition of anesthesia services in its operating rooms."[7]

In addition, the Seventh Circuit expressly instructed the District Court to reexamine, should the case proceed to trial, the possible pro-competitive effects of exclusive contracts. For example, the Court noted the possibility that the exclusive arrangement could *promote* competition among hospitals by creating hospital efficiencies and stimulating competition among anesthesiologists to obtain exclusive contracts.

. . . But Are Unlawful in the Fifth Circuit

A different conclusion was reached by the United States Court of Appeals for the Fifth Circuit in *Hyde v. Jefferson Parish Hospital District No. 2*.[8] In the *Hyde* case, a non-profit hospital entered into an exclusive anesthesiology arrangement with an anesthesiology group. The plaintiff, an anesthesiologist, was refused staff pri-

vileges at the hospital and challenged the validity of the exclusive arrangement under the antitrust laws. Unlike the plaintiff in *Dos Santos,* however, this plaintiff challenged the exclusive contract *not* as unlawful exclusive dealing but as an unlawful tying arrangement; the plaintiff claimed that the hospital ''tied'' the purchase of anesthesiology services to the use of its operating room facilities, such that any patient desiring to use the hospital's operating room was forced — by the exclusive contract — to use the services of the defendant anesthesiology group.

The District Court failed to accept the plaintiff's challenge, finding the exclusive arrangement lawful under the Rule of Reason. In the Court's view, the purpose of the exclusive contract was to enhance patient care and thereby allow the hospital to compete more effectively with other hospitals in the area. Moreover, the District Court found that the actual restraint on competition resulting from the exclusive contract was minimal, and that, because the hospital did not have sufficient market power with respect to the provision of operating room services (the ''tying'' product), the plaintiff had not shown an unlawful tying arrangement.

On appeal, the Fifth Circuit, choosing to disregard both the *Dos Santos* case and cases in several other jurisdictions,[9] reversed the District Court, finding the arrangement constituted a *per se* unlawful tying arrangement. According to the Fifth Circuit, the existence of a ''tying arrangement'' was clear — the users of the hospital's operating rooms were also compelled to purchase the hospital's chosen anesthesia service. This tying arrangement violated the antitrust laws, in the Fifth Circuit's view, because of the fact that the hospital had a degree of market power sufficient to make the tying arrangement effective. This market power arose because approximately 30% of the patients from the hospital's immediate area sought out the services of the hospital.

In reaching its decision, the Fifth Circuit took a novel view of the ''market imperfections'' existing in the health care sector, a view which appears to be diametrically opposed to that espoused by other courts. Specifically, the Fifth Circuit, like other courts, recognized the fact that the market for health care services operated differently from other, more traditional markets (e.g., the market for health care services lacks price competition, since the person receiving the services and the person paying for the services are not the same). Other courts, however, considered the ''imperfections'' in the health care market as perhaps legitimizing actions by health care practitioners and institutions which in other markets would constitute antitrust violations. The Fifth Circuit suggested just the opposite: that, because of the market imperfections, an exclusive contract in the health care market might constitute an antitrust violation when that same contract, in a more traditional market, would not. In other words, rather than utilizing the market imperfections in the health care market to *support* more lenient treatment of exclusive arrangements under the antitrust laws in the health care area (as has been suggested by the United States Supreme Court on several occasions),[10] the Fifth Circuit used those same market imperfections in order to impose a more strict burden upon exclusive arrangements between hospitals and physicians.

Conclusion

The United States Supreme Court has granted the defendants' petition for certiorari in the *Hyde* case, and it is therefore likely that the conflicting results of the *Hyde* and *Dos Santos* opinions will be resolved. In the meantime, however, hospitals and physicians that enter into exclusive arrangements do so at the risk of incurring substantial liability for violating the antitrust laws.

Notes

1. *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975). 2. 15 U.S.C. §14. 3. 15 U.S.C. §1. 4. 684 F.2d 1346 (7th Cir. 1982). 5. *Id.,* at 1352. 6. *Id.,* at 1353. 7. *Id.,* at 1354.

8. 686 F.2d 286 (5th Cir. 1982).

9. See, e.g., *Harron v. United Hospital Center, Inc.,* 522 F.2d 1133 (4th Cir. 1975) (per curiam); *Smith v. Northern Michigan Hospitals, Inc.,* 518 F.Supp. 644 (W.D. Mich. 1981).

10. See, e.g., *Goldfarb v. Virginia State Bar, supra,* 421 U.S. at 788 n.17; *National Society of Professional Engineers v. U.S.,* 435 U.S. 679 (1978).

All That Clicks Is Not Barlow's

THOMAS L. CREWS, M.D., *Covington**

Mid-systolic clicks were first described in France in the late 19th and 20th centuries. These were thought to be due to extracardiac phenomenon, i.e. pleuropericardial adhesions. For many years, the mid-systolic click was thought to be an auscultatory curiosity of no clinical significance or consequence. Reid[1] in 1961 first proposed that the systolic click-late murmur combination was mitral valvular in origin and likely associated with myxomatous degeneration of the mitral valve.

Barlow and associates[2] in a landmark study published in 1963 reported seven cases of late systolic murmur. A mid-late systolic click was associated with the murmur in only three of the seven cases. This study confirmed that these auscultatory findings were generated by the mitral valve. A later study[3] in 1966 reported 90 patients with apical late systolic murmurs, non-ejection clicks or both. This syndrome then became the object of numerous reports in the literature in the late 1960s and through most of the decade of the 70s. Though many designations have been proposed to describe the syndrome, it appears that mitral valve prolapse (M.V.P.) is now the preferred term.[11] Barlow's Syndrome probably should be reserved for the patient with typical clinical, auscultatory and, most importantly, EKG abnormalities.[11] Nonetheless, Barlow's Syndrome continues to be a favorite term among many physicians for *all* patients with M.V.P., and a number of patients find it quite fashionable to have been diagnosed as having Barlow's Syndrome.

Since 17% of the population may have mitral valve prolapse,[5] the systolic click may be early[14] mid or late,[4] may or may not be accompanied by a murmur,[7] and may even be accompanied by a diastolic murmur,[8] the possibilities for confusion and misdiagnosis certainly exist. Foremost in the potential diagnostic pitfalls is the fact that *valvular ejection sounds* have in the past been described as "clicks," since these sounds are sharp and high pitched.

Most authorities agree that a patient presenting with the classic clinical findings of mitral valve prolapse needs no further diagnostic work-up and generally no therapy unless the late systolic murmur is present, in which case SBE prophylaxis is indicated. Several decisions must be made at the bedside in order to feel confident in a diagnosis of M.V.P.

1) Is the click truly a *non*-ejection sound?
2) Is the murmur, if present, originating from the mitral valve?
3) Is the mitral valve prolapse a primary or secondary phenomenon?

The following is a partial listing of diagnoses where a systolic click and murmur or systolic click alone may be present.

Dr. Crews practices cardiology. Send reprint requests to him at 4140 Tate St., NE, Covington, GA 30209.

Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Laurence O. Watkins, M.D., "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

NON-EJECTION

Primary

1. Mitral valve prolapse.
2. Ebstein's anomaly[13] ("Sail sound" after S_1).

Secondary

1. Marfan's.
2. Rheumatic endocarditis.
3. Coronary atherosclerotic heart disease.
4. Mitral valve surgery.
5. Hypertrophic obstructive cardiomyopathy.
6. Congestive cardiomyopathy.
7. Left atrial myxoma.
8. Myocarditis.

EJECTION

Aortic

1. Aortic stenosis. (Bicuspid Valve).
2. Aortic dilatation any cause. (hypertension, dissection, syphilis, aortic regurgitation).
3. Coarctation of aorta. (with bicuspid valve).

Pulmonic

1. Pulmonic stenosis.
2. Pulmonary hypertension.
3. Idiopathic dilatation of pulmonary artery.

"NEITHER"

1. Pacemaker sound.[15] (Precedes S_1 so that pacemaker sound may be mistaken for S_1 and S_1 for click or ejection sound).
2. Mediastinal Emphysema.[4]
3. Left Pneumothorax.[4]

The patient's medical history and a cursory inspection of the chest will immediately lead to the correct diagnosis in several of the abnormalities. In a number of the above clinical problems, however, the history may be completely nonspecific. Symptoms may be totally absent, and the patient may have no complaints whatever; or complaints of palpitation, light-headedness, fatigue, dizziness, and syncope could be common to many cardiac and non-cardiac problems.

Physical examination will generally very rapidly categorize the click-murmur or click alone as being ejection, non-ejection, or extracardiac. Simultaneous auscultation and carotid artery palpation should establish whether or not the auscultatory findings are coming from the aortic valve. If the click occurs well before the peak of the carotid upstroke, then it is most likely ejection and related to the aortic valve. An exception to this would be a click occurring with a markedly dilated aorta and caused by abrupt distention of the aortic wall. This would occur late and near the peak of the carotid pulse wave. This is, however, a very rare finding. The aortic valve ejection sound is heard quite well at the base of the heart but is well transmitted to the mitral area. This sound does not vary with respiration or with different body positions.

Pulmonic ejection sounds are classically heard best at the base of the heart over the pulmonic area. These sounds are not well transmitted to the mitral area. Pulmonic ejection sounds are characterized by specific respiratory variation. The sound increases considerably with expiration and decreases with inspiration.

Extracardiac sounds should give rise to little or no difficulty. The extracardiac clicking sound described with mediastinal emphysema has a crunching, crackling quality. The clicking sounds associated with left pneumothorax vary with respira-

tion and posture and, in addition, the patient should be complaining of pain and shortness of breath.

In the case of mitral valve prolapse, a number of maneuvers should be carried out in order to assess the behavior of the click and murmur. In general, manuevers increasing venous return to the heart and hence making left ventricular size larger, will decrease the intensity of the click and murmur as well as move the click and murmur later into systole. On occasions, both click and murmur may disappear with manuevers such as leg-raising or squatting. On the other hand, maneuvers that decrease venous return and hence left ventricular volume, move the click and murmur closer to the first heart sound and lengthen the systolic murmur. On occasions, a murmur may be brought out under these circumstances where it was inaudible with the patient lying on the examining table at 30° elevation. Consequently, examination for mitral valve prolapse should always include auscultation with the patient standing.

A most careful physical examination may fail to differentiate between mitral valve prolapse and hypertrophic obstructive cardiomyopathy, since the above described maneuvers will have similar effects on the auscultatory findings in both conditions. If the carotid pulse is classic, i.e. spike-and-dome, then the differentiation is made much easier. If ventricular ectopic beats are present, then the murmur of hypertrophic obstructive cardiomyopathy increases in intensity, whereas the murmur of mitral valve prolapse tends to decrease.

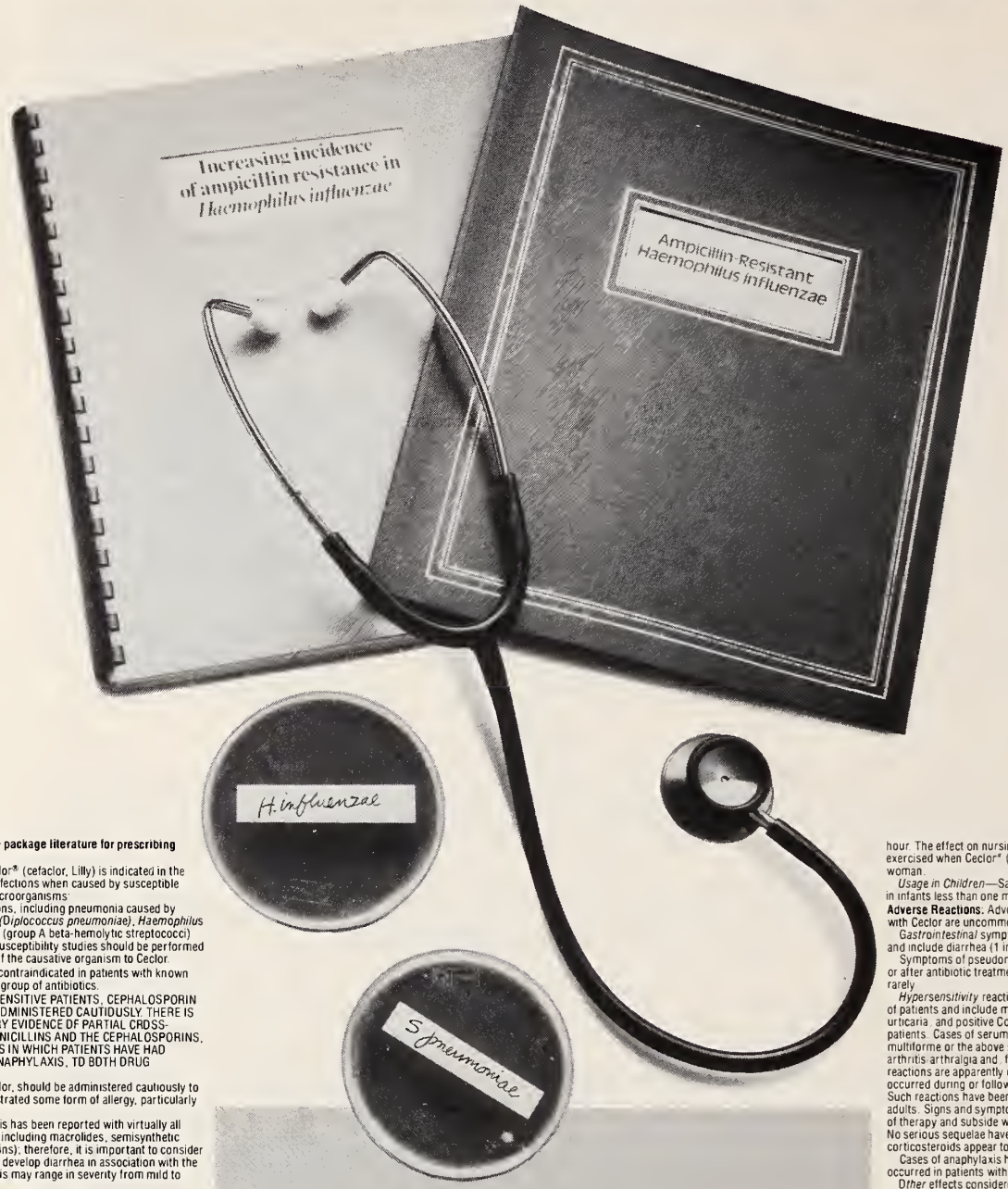
A diagnosis of mitral valve prolapse can never be confidently made or excluded if the patient is examined only in one position for a very brief period.

All that clicks is not mitral valve prolapse.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 2 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. The reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 1[illegible] patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[0617[illegible]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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president's letter



Doctoring and Lawyering

It is both surprising and disturbing to discover how much of doctoring is necessarily related to lawyering. In my brief span at the helm of this organization of more than 5000 doctors, I am absolutely astounded at how much of the important business of the Association is related to lawyering. It is a frustrating experience. I would commend to you Art Buchwald's column in the *Atlanta Journal* of 6/13/83 headlined "Lawyering Is Only True Perpetual Motion Machine." Dealing with lawyers in an associational capacity is a whole new growing up experience. There is a great similarity to being a teenager who knows exactly what he wants to do and is very determined to do it and suddenly finds himself balked by a parental intervention that says, "You better not do that or else such and such is going to happen." It is very difficult to deal with that. You want to rail and scream and holler and stamp your feet and plow on!! But with the turning of the clock, you realize that for what they say at the Mayo Clinic is "a variety of reasons," one has to slow down the attack, fall back, retreat, and obey the parental directive. It does not come easy, and the only reconciliation comes in the fact that as time goes by, just as our parents seemed wiser and more correct, for the most part so do our lawyers. As a matter of record, however, let this little squib be a notice to them that they had better be right!

Our two professions are going through times in which we are both accused of over-production, over-utilization and over-pricing. Both of us need to be sensitive to these accusations and if we are going to defend them, be prepared to do so with fact, energy, and lots of money.



William W. Moore, Jr., M.D.

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PERSONALS

First District

Charles Gray Green, Jr., M.D., of Augusta, was elected to Fellowship in the American College of Physicians. Dr. Green, who specializes in internal medicine-diabetes, was honored during the college's annual session in San Francisco in April.

Third District

Columbus physician, **Howard C. McMahan, M.D.,** was recently named Family Practice Resident of 1982-83 by the Medical Center, Columbus.

Fifth District

John E. Skandalakis, M.D., an Atlanta general surgeon, was elected chairman of the Board of Regents of the University System of Georgia. Dr. Skandalakis, a Distinguished Professor at Emory University School of Medicine, had been appointed in 1981 to a 7-year term as a Regent.

Jeffrey T. Nugent, M.D., an orthopaedic surgeon, has been nominated without opposition as president-elect of the Medical Association of Atlanta.

Gerald W. Staton, Jr., M.D., Assistant Professor of Medicine (Pulmonary Diseases) at Emory University School of Medicine, recently presented a paper entitled, "Comparison of Clinical Evaluation, Bronchoalveolar Lavage, Gallium-67 Lung Uptake and Serum Angiotensin Converting Enzyme Levels in the Assessment of Pulmonary Sarcoidosis" to the American Thoracic Society Annual Meeting in Kansas City, MO. Dr. Staton's work is supported by a grant from the Georgia Lung Association. In addition, Dr. Staton has recently been awarded a research grant in the amount of $99,000 from the Carlyle Fraser Heart Fund for the study of mechanisms of lung injury in a number of diseases.

Nanette K. Wenger, M.D., F.A.C.C., of Atlanta, was elected to serve as College Governor for the state of Georgia by the American College of Cardiology's (ACC) Board of Trustees.

Seventh District

Rome physician, **Warren M. Gilbert, M.D.,** a founding member of the Harbin Clinic, retired May 31 after 50 years of practice. Dr. Gilbert is a past president of the Floyd County Medical Society and the 7th District Medical Society. He was a member of the American College of Physicians.

Eighth District

W. R. Baker, M.D., of Hawkinsville, was honored recently during National Hospital Week observations in Pulaski County for his service and dedication to the residents of Hawkinsville.

Tenth District

Donald L. Branyon, Jr., M.D., F.A.C.O.G., of Athens, was elected chairman of the Georgia Section of the American College of Obstetrics and Gynecology for a 3-year term.

Augusta physician, **Carol G. Pryor, M.D.,** was appointed to the Georgia College Foundation Board of Trustees.

William Joseph Wylie, M.D., of Augusta, has been elected to Fellowship in the American College of Cardiology.

Henry F. Yost, M.D., clinical director at the Georgia Regional Hospital at Augusta, was elected president-elect of the Central Savannah River Area Psychiatric Association.

Stanley Thomas Smith, Jr., M.D., of Augusta, has been elected to Fellowship in the American College of Physicians.

SPECIALTY SOCIETIES



James Clinton Joiner III, M.D.
President, Georgia Society of Ophthalmology

The following officers and councilmen of the Georgia Society of Ophthalmology were elected to serve from May 1983 to May 1984:

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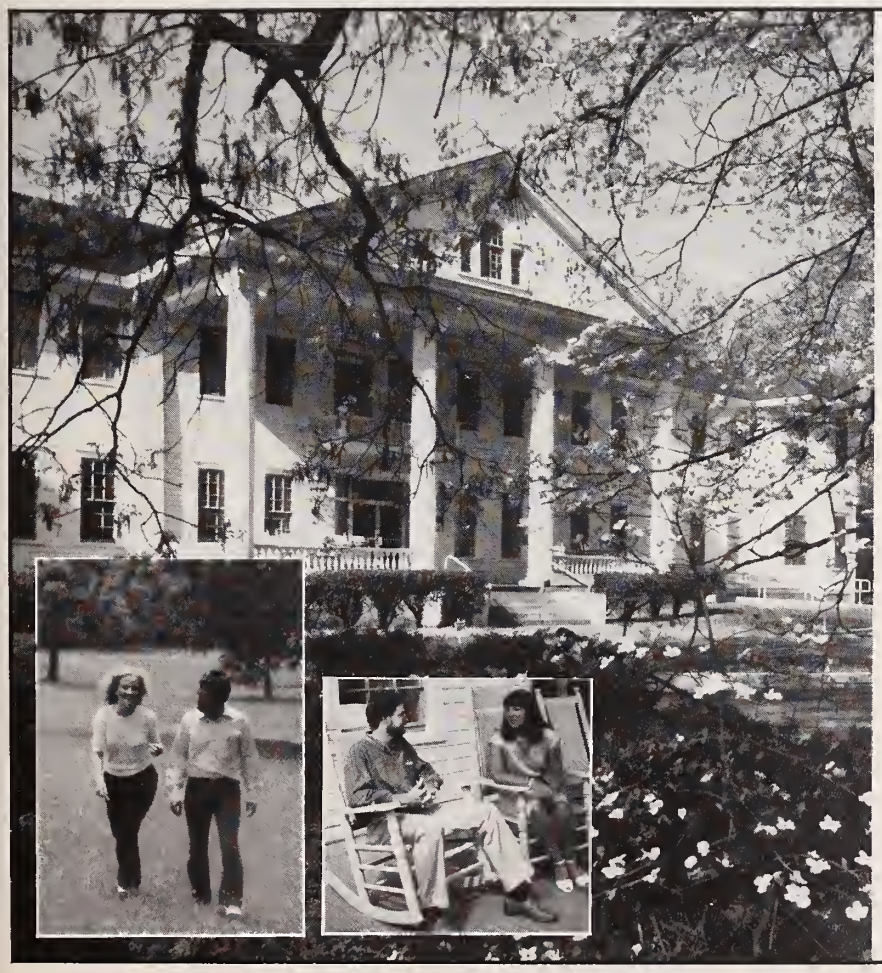
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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

This month features highlights of the MAG's upcoming Scientific Assembly in November. Peruse the information so you can make informed choices about your continuing education.

Cover artwork by Ms. Dottie Crane, Atlanta.

Inflammatory Bowel Disease: Newer Developments in Medical Treatment, Pathology, and Operative Management—

is the title of a symposium for physicians to be presented October 14, 1983*, in Birmingham, Alabama.

The symposium, which will provide physicians with seven (7) hours of Continuing Medical Education (CME) credit, Category I ,is sponsored by **South Highlands Hospital** and coordinated by Dr. Arthur M. Freeman, Jr. It will be held at the Birmingham Hilton —808 South 20th Street, Birmingham, Alabama from 9:00 A.M. until 5:00 P.M.

A block of rooms has been reserved at the Birmingham Hilton for the meeting. The fee for the seminar is $40, which includes lunch. For further information and to register, contact: Mrs. Dena Metts, Medical Staff Coordinator, South Highlands Hospital, 1127 South 12th Street, Birmingham, Alabama 35205. **Phone: (205) 250-7703.**

*October 14th is the day prior to the Alabama/Tennessee football game.

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MEDICAL MEETING CALENDAR

AUGUST

24-28—*Hilton Head, SC:* **Summer Imaging.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

25-28—*Savannah:* **Georgia Psychiatric Association Annual Meeting.** Category 1 credit. Contact Samuel Brown, MD, Chairman, Comm. on CME, Ga. Psy. Assn., 3280 Howell Mill Rd., Ste. 212, NW Med. Ctr., Atlanta 30327. PH:404/351-2330.

27-28—*Callaway Gardens:* **Medical Malpractice and the Anesthesiologist.** Category 1 credit. Contact William Hammonds, MD, Secy-Treas., Ga. Socy. of Anesthesiologists, Emory Univ. Hosp., Dept. of Anesth., 1364 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111.

SEPTEMBER

1-4—*Sea Island:* **Tri-State Otolaryngology Assembly.** Category 1 credit. Contact Warren Griffin, MD, Program Chairman, 800 First St., Macon 31201. PH:912/743-8953.

11-14—*Sea Island:* **Annual Meeting—Georgia Urological Association.** Contact Richard Estes, MD, Secy-Treas., 35 Collier Rd., NW, Atlanta 30309. PH:404/355-0813.

12-14—*Atlanta:* **Echocardiography.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-16—*Savannah:* **Neonatology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

15-17—*Sea Island:* **Georgia Surgical Society Annual Meeting.** Category 1 credit. Contact William C. McGarity, MD, Secy-Treas., Emory Univ. Clinic, 1365 Clifton Rd., NE, Atlanta 30322. PH:404/321-0111, x3322.

23-25—*Atlanta:* **MAG Risk Management Seminar.** Category 1 credit. Contact Denise Alper, Piedmont Hospital, 1938 Peachtree Road, NW, Atlanta 30309. PH:404/355-7611, x 3317.

26-29—*Atlanta:* **Demonstrations in Percutaneous Transluminal Angioplasty.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

OCTOBER

2-7—*Hilton Head, SC:* **Review and Update in Medicine.** Cosponsored by Med. Univ. of S.C. and USC Sch. of Med. Category 1 credit. Contact Daryl Walker, South Carolina Med. Assn., P.O. Box 11188, Columbia, SC 29211. PH:803/252-6311.

6-8—*Hilton Head, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

7-8—*Atlanta:* **Gynecologic Oncology Update: 1983.** Co-sponsored by the Georgia Chapter, American Cancer Society. Category 1 and AAFP prescribed credits. Contact Arnold Bernstein, MD, Prog. Chmn., Georgia Baptist Med. Ctr., 340 Boulevard, NE, Atlanta 30312. PH:404/577-1555.

7-9—*Savannah:* **Recent Advances in Hypertension and Cardiology.** Sponsored by the Georgia Affiliate of the American Heart Association. Contact Mary Johnson at the AHA, P.O. Box 13589, Atlanta 30324. PH:404/261-2260.

8-12—*Atlanta:* **American Society of Anesthesiologists.** Contact ASA, 515 Bussee Hwy., Park Ridge, IL 60068. PH:312/825-5586.

10-13—*Atlanta:* **ACC Board Review.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Columbus:* **MAG Risk Management Seminar.** Cosponsored by the Muscogee County Medical Society. Category 1 credit. Contact Barbara Dent, Exec. Secy., Muscogee County Medical Society, 232 Doctors Building, Columbus 31901. PH:404/322-1254.

14-16—*Augusta:* **Medical Fair and Pre-Practice Seminar for Residents.** Contact Gould Hagler, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll-free in Ga.)

16-21—*Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

19-22—*Hilton Head, SC:* **Fifth Annual Hilton Head Symposium on the Clinical Management of Diabetes and Endocrine Disorders.** Category 1 and AAFM prescribed credits. Contact Edwin Bransome, Jr., MD, Dept. of Med., MCG, Augusta 30912. PH:404/828-3445.

22-27—*Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P. O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

NOVEMBER

4—*Atlanta:* **Birth Defects: A Challenge to Families and Health Care Professionals.** Contact Stephen Daniel, Ph.D., Dir. of CME, Morehouse Sch. of Med., 720 Westview Dr., S.E., Atlanta 30310. PH: 404/752-1351.

9-13—*Atlanta:* **Georgia Academy of Family Physicians Annual Scientific Assembly.** Category 1 and AAFP prescribed credit. Contact GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

11-12—*Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., 3280 Howell Mill Rd., NW, Ste. 206, Atlanta 30327. PH:404/351-2713.

17-20—*Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester C. Lane, Exec. Secy., 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

18-20—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree Street, NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

30-Dec. 4—*Atlanta:* **Eighth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

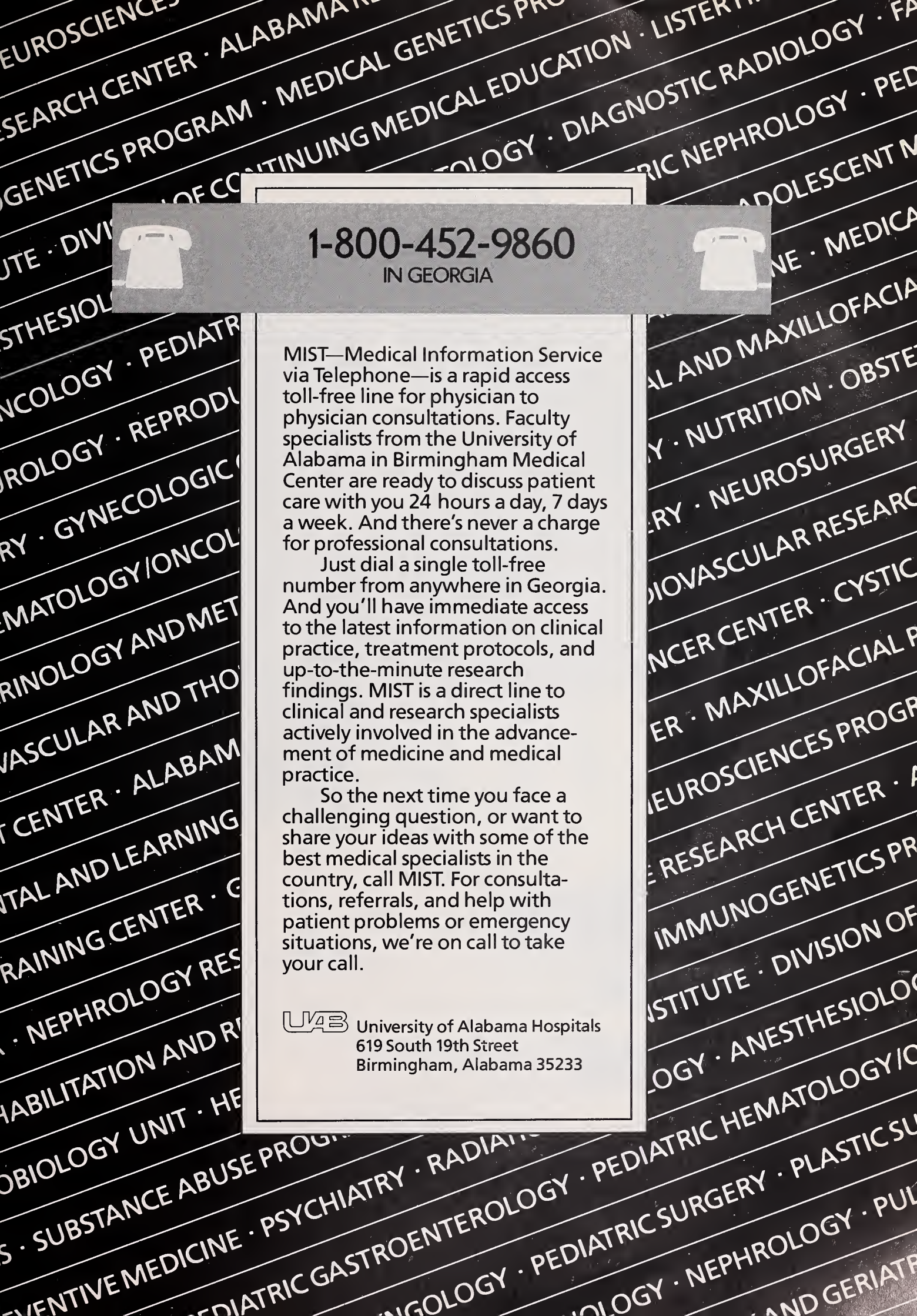
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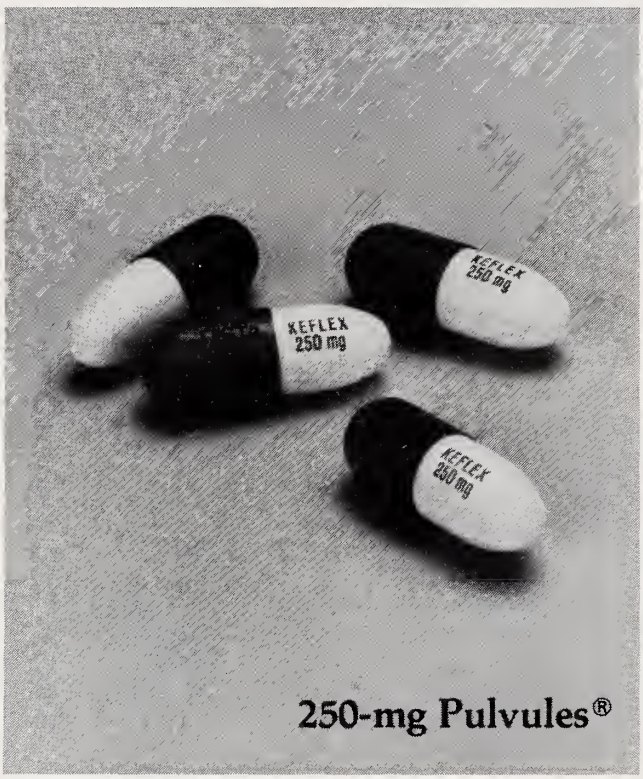
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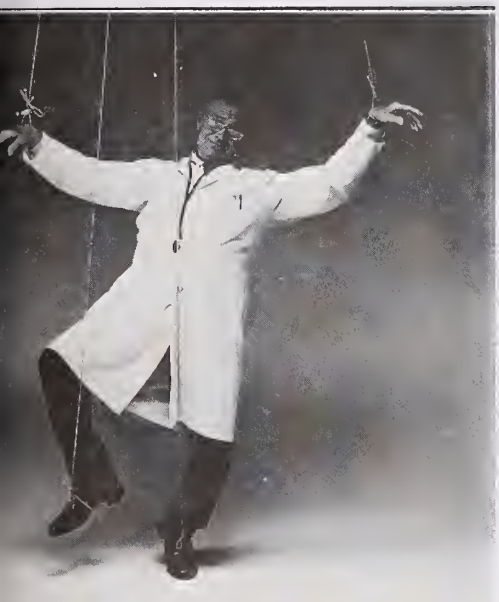


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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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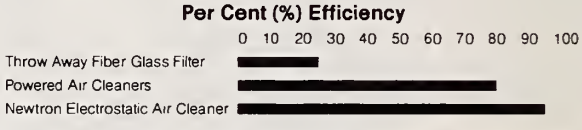
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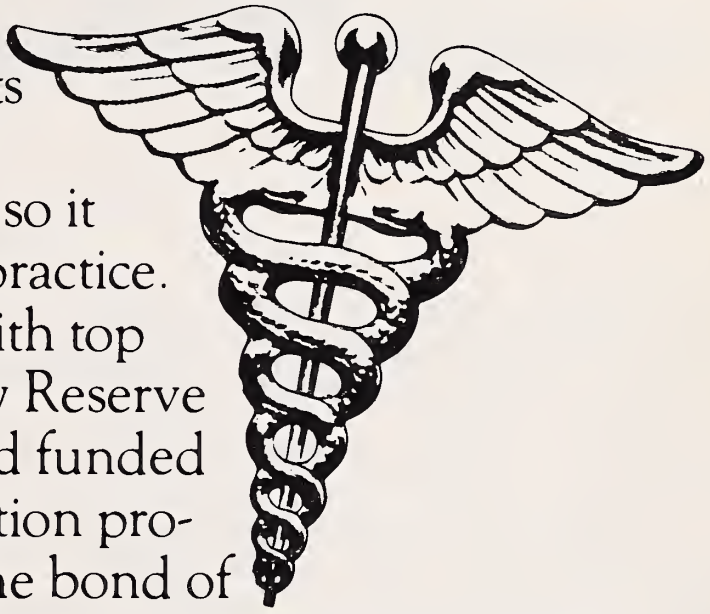
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"SPECIALTY SOCIETIES come together. MAG handles the details. You get the rewards."

***A brief look at our Scientific Assembly, scheduled for November 18-20 at the Colony Square Hotel in Atlanta. The complete program will appear in next month's* Journal.**

That's the way our Scientific Assembly has worked, and it seems to be working well. Our format allows state specialty societies to select the educational topics and speakers preferred by them. The staff of the MAG coordinates publicity and registration and makes arrangements for meeting rooms, audiovisual needs, coffee breaks, etc. From registration fees received, the MAG in turn helps societies pay for their speakers.

This fall, the Scientific Assembly of the Medical Association of Georgia will meet in Atlanta, at the Colony Square Hotel. Our scheduled dates are November 18-20 (Friday-Sunday). Fourteen specialty programs will be presented during the weekend, each of which will be accredited for AMA Category 1 hours and other specialty credit designations.

* Dr. Keener, a neurosurgeon, is Chairman of MAG's Committee on Scientific Assembly. Send reprint requests to the MAG, c/o Scientific Assembly.

Specialty Societies Participating in This Year's Scientific Assembly

Allergy: Allergy and Immunology Society of Georgia
Program Chairman: David B. Tanner, M.D., Atlanta

Chest Disease: Georgia Thoracic Society
Program Chairman: Jonne Walter, M.D., Atlanta

Georgia Chapter, American College of Chest Physicians
Program Chairman: Walter S. Dunbar, M.D., Atlanta

Emergency Medicine: Georgia Chapter, American College of Emergency Physicians
Program Chairman: Gail Anderson, M.D., Atlanta

Gastroenterology: Georgia Gastroenterological Society
Program Chairman: Paul R. Rodzewicz, M.D., Atlanta

Neurology: Georgia Neurological Society
Program Chairman: Mark Kozinn, M.D., East Point

Neurosurgery: Georgia Neurosurgical Society
Program Chairman: Robert E. Dicks, III, M.D., Athens

Ophthalmology: Georgia Society of Ophthalmology
Program Chairman: David Campbell, M.D., Atlanta

Otolaryngology: Georgia Society of Otolaryngology — Head and Neck Surgery
Program Chairmen: William E. Silver, M.D., Atlanta; Albert A. Clairmont, M.D., Atlanta
Pathology: Georgia Association of Pathologists
Program Chairman: Alex T. Parkinson, M.D., Snellville
Atlanta Society of Pathologists
Program Chairman: Jerry D. Porter, M.D., Atlanta
Pediatrics: Georgia Chapter, American Academy of Pediatrics
Program Chairman: George Brumley, M.D., Atlanta
Plastic Surgery: Georgia Society of Plastic Surgeons
Program Chairman: Robert Zaworski, M.D., Roswell
Psychiatry: Georgia Psychiatric Association
Program Chairman: Donald Manning, M.D., Atlanta
Rheumatism: Georgia Rheumatism Society
Program Chairman: Sanford S. Hartman, M.D., Decatur
Surgery: Georgia Chapter, American College of Surgeons
Program Chairman: Eugene D. Davidson, M.D., Atlanta

Registration Information

Please register for the Scientific Assembly by completing the registration form inserted in the back of this *Journal,* detaching it from the hotel reservation form, and mailing it with your registration fee to the MAG headquarters office.

Registration fee for physicians: MAG MEMBER — $50; NON-MEMBER — $75. Fee for other health professionals is $20.

There is NO FEE for resident physicians, medical students, program chairmen or speakers.

Hotel Reservations

If you wish hotel accommodations, please complete and detach the bottom portion of the registration form and mail it directly to the Colony Square Hotel by October 27, 1983. As stated on the hotel card, Thursday reservations must be guaranteed. Should you not arrive on this date or call in the cancellation before 6 p.m., you will be billed for both the room and tax. Friday and Saturday reservations will be held until 6 p.m. unless guaranteed or covered by deposit.

Highlights of the Weekend

The full program for all specialties will be printed in the October *Journal of the Medical Association of Georgia*. But here are a few highlights for some of our sessions:

Friday, November 18

Topics in Critical Care (Cosponsored by the Georgia Thoracic Society, Georgia Gastroenterological Society, and Georgia Chapter, American College of Surgeons)
—"Hemodynamic Monitoring" and "Shock," Roger Bone, M.D.
—"Nosocomial Respiratory Infection," Waldemar Johanson, M.D.
—"Acute Renal Failure," Carl Oettinger, M.D.
—"Massive GI Bleeding," H. Worth Boyce, M.D.
—"Nutrition in the Critically Ill (Hyperalimentation)," James L. Mullen, M.D.
—"Blood Substitutes," Stan Mogelnicki, M.D.

Managing the Arthritic Patient (Sponsored by the Georgia Rheumatism Society)
Charles Plotz, M.D. (Professor of Medicine, Downstate Medical Center, New York), and M. Thomas Stillman, M.D. (Director of Rheumatology, Hennpin Co. Medical Center, University of Minnesota Medical School), will present cases of patients with specific types of arthritic problems frequently encountered in daily practice. The program, a collaborative effort of the Arthritis Foundation and Syntex Laboratories, has been prepared in cooperation with the American Academy of Family Physicians.

Allergy (Sponsored by the Allergy and Immunology Society of Georgia)
—"Persistent Small Airways Disease," Arlene Hutcheson, M.D.
—"Case Presentations," Larry Smith, M.D.
—"Progressive Allergy," Kenneth Pearce, M.D.

Otolaryngology/Head and Neck Surgery (Sponsored by the Georgia Society and Atlanta Society of Otolaryngology-Head and Neck Surgery)
—"Airway Problems in Children," Robin Cotton, M.D.
—"Laryngotracheal Trauma," Edward Porubsky, M.D.
—"CSF Otorrhea and Rhinorrhea Following Head Trauma," Newton Coker, M.D.
—"Pulmonary Function Studies for Evaluation of the Preoperative and Postoperative Head and Neck Surgical Patient," Gary Lohaus, M.D.
—"Treatment of Traumatic Nasal Injury," William E. Silver, M.D.

Pediatrics (Sponsored by the Georgia Chapter, American Academy of Pediatrics)

—"The Basics of Adolescent Medicine," Alan J. Sievert, M.D.

—"Collagen Vascular Disease Update," Donna L. Gibbas, M.D.

—"Increased Intracranial Pressure," Peter A. Ahmann, M.D.

Saturday, November 19

Pulmonary Topics in Critical Care (Sponsored by the Georgia Thoracic Society)

—"Acute Respiratory Failure," Roger Bone, M.D.

—"Nosocomial Infection in Acute Respiratory Failure," Waldemar Johanson, M.D.

—"The Respiratory Muscles — A General Introduction," Eric Honig, M.D.

—"Muscles, Fatigue and Weaning from Ventilatory Support," Dr. Honig

—"Nutritional Support in Respiratory Failure," Gilbert Grossman, M.D.

Emergency Medicine (Sponsored by the Georgia Chapter, American College of Emergency Physicians)

—"Update on Emergency Department Management of Sexually Transmitted Diseases," Stephen Kraus, M.D.

—"Hand Injuries in the Emergency Department," Foad Nahai, M.D.

—Lab Demonstration: "Techniques of Plastic Wound Management in the Emergency Department," Dr. Nahai

Neurology (Sponsored by the Georgia Neurological Society)

Among the faculty will be J. Baldwin Smith, M.D., of the Bowman Gray School of Medicine, Winston-Salem, N.C., who will speak on epilepsy.

Neurosurgery (Sponsored by the Georgia Neurosurgical Society)

Among the faculty will be Steven L. Gianotta, M.D., of the University of Southern California Medical School speaking on topics in neurosurgical critical care.

Ophthalmology (Sponsored by the Georgia Society of Ophthalmology)

David L. Epstein, M.D., Associate Professor of Ophthalmology at Harvard Medical School and Director of the Glaucoma Service at the Massachusetts Eye and Ear Infirmary, will be guest speaker. GSO members will also present papers.

Pathology of the Acquired Immune Deficiency Syndrome (AIDS) (Sponsored by the Georgia Association of Pathologists)

This program will review the epidemiology, immunology, and histopathology of the syndrome. Special attention will be focused on change seen in the lymphoreticular system, Kaposi's sarcoma, and other malignancies associated with the syndrome, and morphological manifestations of opportunistic infections. Codirectors will be Russell K. Brynes, M.D., Associate Professor of Pathology and Laboratory Medicine, Emory University School of Medicine, and Edwin P. Ewing, Jr., M.D., Chief of the Ultrastructural Pathology Section, Centers for Disease Control.

Pediatrics (Sponsored by the Georgia Chapter, American Academy of Pediatricians)

—"Hypertension: Evaluation and Management," Leonard C. Hymes, M.D.

—"Renal Transplant — Current Status," Barry L. Warshaw, M.D.

—"Reactive Airway Disease," Thomas F. Smith, M.D.

—"Viral Myocarditis," Harry F. Keyserling, M.D.

Plastic Surgery (Sponsored by the Georgia Society of Plastic Surgeons)

Stephen J. Mathes, M.D., Associate Professor of Surgery, University of California-San Francisco School of Medicine, will speak on "Coverage of the Infected Wound" and "Current Concepts in Head and Neck Reconstruction."

Psychiatry (Sponsored by the Georgia Psychiatric Association)

—"Advances in Antidepressant Medication," Richard L. Borison, M.D., Ph.D.

—"Treatment of Pain Syndromes," Jeffrey L. Houpt, M.D.

—"Biological and Treatment Advances in Anxiety," Philip T. Ninan, M.D.

—"Alcoholism," E. Mansell Pattison, M.D.

—"The Interface of Medicine and Psychiatry in the Eighties," Carol Ann Phillips, M.D.

—"Management of the Somatizing Patient," Alan Stoudemier, M.D.

—"Grieving — Blocks and Resolution," Richard W. Baggé, M.D.

Surgery (Sponsored by the Georgia Chapter, American College of Surgeons).

James L. Mullen, M.D., of the University of Pennsylvania, will speak on "Nutritional Assessment and Alimentation in Cancer Patients." ACS members and residents will also present papers on Glioblastoma Multiforme, Trauma During Pregnancy, Surgeons in Small Georgia Towns, the Anterior Talofibular Ligament, the Spleen in

THE WEEKEND AT A GLANCE

FRIDAY, NOVEMBER 18		SATURDAY, NOVEMBER 19		SUNDAY, NOVEMBER 20
Morning	Afternoon	Morning	Afternoon	Morning
	ALLERGY			
TOPICS IN CRITICAL CARE (Chest Disease-Gastroenterology-Surgery)		PULMONARY TOPICS IN CRITICAL CARE (Chest Disease)		
			EMERGENCY MEDICINE	
		NEUROLOGY		
		NEUROSURGERY		
		OPHTHALMOLOGY		
OTOLARYN-GOLOGY				
		PATHOLOGY		PATHOLOGY
PEDIATRICS				
MANAGING THE ARTHRITIC PATIENT				
		PLASTIC SURGERY		
		PSYCHIATRY		
		SURGERY		

Trauma, Intraoperative Thrombophlebitis Prophylaxis, Gastroschisis, Breast Reconstruction by Natural-Y Prostheses, Evaluation of Carotid Arteries, Biliary Atresia and Gastric Bypass.

Sunday, November 20

Pathology of Neoplastic Lymphoproliferative Disorders (Sponsored by the Atlanta Society of Pathologists)

The ASP Annual Slide Seminar will feature Robert D. Collins, M.D., Professor of Pathology, Vanderbilt University School of Medicine. Dr. Collins is a respected national expert in lymphoma research and collaborated with Dr. Robert J. Lukes in their well-known lymphoma classification scheme.

REGISTRATION FORM

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NOVEMBER 18-20, 1983
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- ☐ Emergency Medicine
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- ☐ Pathology
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- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Rheumatism
- ☐ Surgery

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Percutaneous Removal of Stones in the Kidney and Ureter

THOMAS W. SCHOBORG, M.D., BARRY JEFFRIES, M.D., A. P. RODRIGUEZ, M.D., CYRUS M. CIOFFI, M.D., THOMAS R. FULLER, M.D., and CHARLES SCOTT, M.D., *Atlanta**

Abstract

Since December of 1982, we have attempted percutaneous stone removal in the kidney or ureter in 25 patients utilizing either the Wolf universal nephroscope or the Olympus CHF-4B flexible nephroscope. Complete success was achieved in 23 patients. The two incomplete removals consisted of one patient with a horseshoe kidney whose renal pelvis stone was removed, but residual calyceal calculi remained, and one patient whose pyelonephritic kidney was so chronically inflamed that no normal structures could be visualized. Complications consisted of significant retroperitoneal extravasation of fluid in one patient and temporary fever in 85% of patients. Approximately 45% of patients required narcotic analgesic postoperatively. The average operative time was 75 minutes, hospital stay 3-5 days, with the possibility of returning to work in 1 week. All renal anatomic variants except pelvic kidney were approached successfully, and stones in all locations of the kidney and ureter were removed successfully.

Introduction

PERCUTANEOUS nephrostomy was first described by Goodwin[1] in 1955. In 1976, Fernstrom[2] reported a successful percutaneous pyelolithotomy in the Scandinavian literature. Others have since removed upper urinary calculi, usually through established nephrostomy tracts; however, Alken[3] first described primary percutaneous approach to the kidney using ultrasonic lithotripsy in 1981 in Germany; and Segura[4] and Kahn[5] further advanced the technique in the United States using the Wolf universal nephroscope and ultrasonic lithotrite. In addition, percutaneous nephroscopy with electrohydraulic lithotripsy and removal of upper urinary calculi has been introduced and advanced by Clayman[6] at the University of Minnesota. Having been introduced to the subject and instructed by the group at the University of Minnesota, we wish to report the results of a series of 25 patients whose stones in the upper urinary tract were percutaneously removed since December of 1982.

Materials and Methods

There were 18 male and 7 female patients aged 21 to 70 who were considered candidates for the procedure. All patients had symptomatic calculi, presenting usually with pain and hematuria. No patients with asymptomatic calyceal calculi were thought to be candidates for this or any other invasive procedure. The locations of the stones were as follows: 13 renal pelvis, 2 ureteropelvic junction, 4 upper or midureteral, 3 renal pelvis and calyceal, 2 anterior inferior calyceal (symptomatic), and 1 staghorn calyceal. The various renal anatomic variants were as follows: 22 normal (bilateral), 2 horseshoe, and 1 bifid renal pelvis. No anatomic variant was considered a contraindication, and only very large staghorn stones were excluded as candidates.

All patients were generally prepared as set forth in the University of Minnesota protocol[7] with a few variations. Patients were admitted to the Urology Service the evening before surgery when an IVP was performed. Prior to percutaneous nephrostolithotomy the next morning antibiotics were administered

* From the Departments of Urology and Radiology, Georgia Baptist Medical Center, Atlanta. Send reprint requests to Dr. Schoborg c/o Atlanta Urological Group, 340 Boulevard, NE, Suite 11, Atlanta, GA 30312.





Figures 1 and 2 — Scout film and IVP of patient with horseshoe kidney.





Figures 3 and 4 — Another patient with bifid renal pelvis whose stone was subsequently successfully removed.





Figures 5 and 6 — Scout film and IVP of another patient with horseshoe kidney.



Figure 7 — Post nephrostolithotomy film in the same patient as Figures 5-6.

intramuscularly 1 hour prior to surgery. In a specially adapted operating room, the radiologist, in consultation with the urologist, determined the best approach for nephrostomy placement to allow adequate mobility of the nephroscope to perform the stone extraction. This would depend on the position of the stone and the anatomy of the collecting system. A 6F ureteral catheter was then introduced by the urologist and the collecting system opacified via this catheter. A secondary purpose of this catheter was to prevent migration of fragments into the ureter. The patient was then placed in an oblique prone position, prepped and draped. Percutaneous approach was performed by the radiologist utilizing fluoroscopic guidance. Following entry into the collecting system, the tract was dilated to 24F using a combination of dilating catheters and balloon dilatation catheters. A safety guidewire as outlined by the Minnesota protocol was always utilized. A Wolf universal nephroscope was then inserted, and clots irrigated out. Through this size tract, stones up to 1.2 cm. in diameter could be easily extracted with the three-pronged Wolf accessory grasper. Larger stones required insertion of the ultrasonic wand and subsequent lithotripsy and suctioning.

For stones not safely accessible via the rigid instrument, an Olympus CHF-4B flexible nephro-

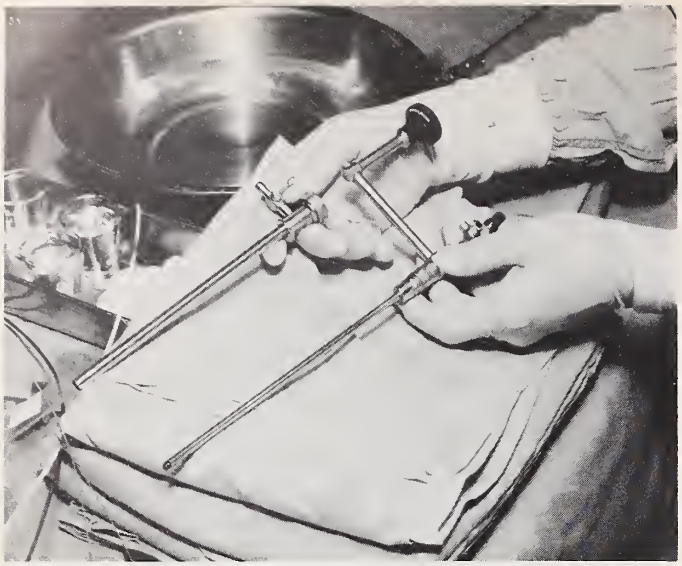


Figure 8 — Wolf rigid nephroscope

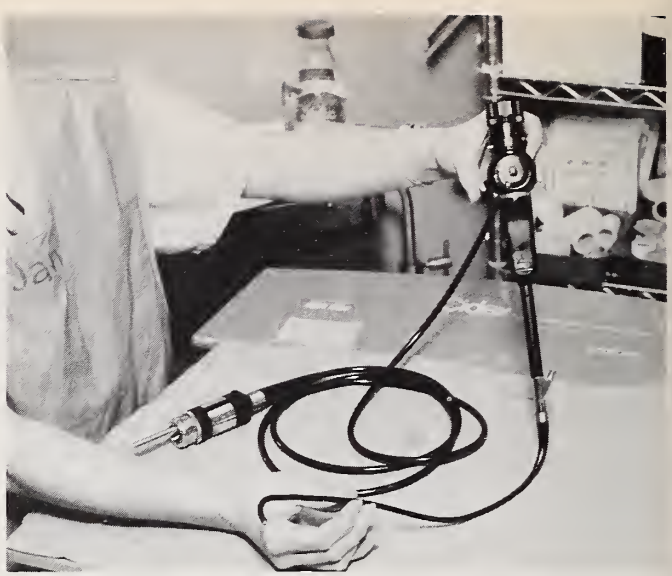


Figure 9 — Olympus flexible nephroscope

scope was inserted through the sheath of the Wolf nephroscope if minimal bleeding was present, and stones thereby removed (usually ureteral stones).

Following stone removal, a #20F Council catheter with a guidewire hole in the tip was inserted under fluoroscopy and sutured to the skin. The patient was discharged the next or following day(s) on antibiotics. If all stones had been removed as verified by nephrostogram 5 days later, the tube was removed, and the patient was allowed to return to work that week. If more stones remained, or if bleeding was excessive during the first examination, flexible nephroscopy and stone extraction with graspers, baskets, and electrohydraulic lithotripsy was performed a minimum of 5 days following nephrostomy placement as an out-patient under local anesthesia, and the nephrostomy tube removed that same day.

Results

All patients with stones in the renal pelvis had their stones successfully removed during the first attempt, including the patients with the horseshoe kidney and bifid renal pelvis (Figures 1-4). Five patients required ultrasonic lithotripsy. Of the two patients with stones at the ureteropelvic junction, one patient had a stone removed during the first procedure. In the other patient, who presented with a translucent filling defect, no stones could be found with either the rigid or flexible nephroscope. She is presently asymptomatic with no catheter drainage. Of those four patients with stones in the ureter, two had stones removed during the first procedure and two required subsequent flexible nephroscopy for ultimate stone removal.

Of the three patients with stones in both the renal pelvis and calyces, all had successful removal of pelvic stones during the first procedure, and two of the three have had their calyceal stones removed subsequently during flexible nephroscopy. In the third patient (with a horseshoe kidney), despite repeat flexible nephroscopy with attempted electrohydraulic lithotripsy, two stones in the inferior calyces could not be extracted, and it was thought clinically unnecessary to persist (Figures 5-7).

The one symptomatic patient with a lower anterior calyceal stone (pain and recurrent *Klebsiella* urinary tract infection) had her stone removed with the rigid nephroscope at the first procedure using the Wolf 3-pronged grasper. The final patient with multiple calyceal staghorn calculi awaits flexible nephroscopy with either electrohydraulic lithotripsy or chemolysis with stone dissolution.

At present, there has been complete success in extracting all symptomatic calculi with only one patient retaining residual calyceal calculi, which admittedly may enlarge and be a source of persistent urinary tract infection. Another patient awaits future nephroscopy. No failures to successfully enter the collecting system percutaneously occurred.

Regarding complications, only 45% of patients required intramuscular analgesics, no patients bled significantly, about 85% experienced temporary fever, and one patient had extravasation of irrigating fluid retroperitoneally from a perforation of the renal pelvis probably occurring during initial insertion of the nephroscopic sheath and trocar. Four days later, the patient experienced a myocardial infarction while at home and has subsequently done well with good drainage noted on a nephrostogram performed 9 days after the initial removal of his left renal pelvis stone.

Total operative time, initially 2-3 hours due to lack of coordination and experience, has been reduced to less than an hour for stones not requiring lithotripsy. Lithotripsy, however, has not added sig-

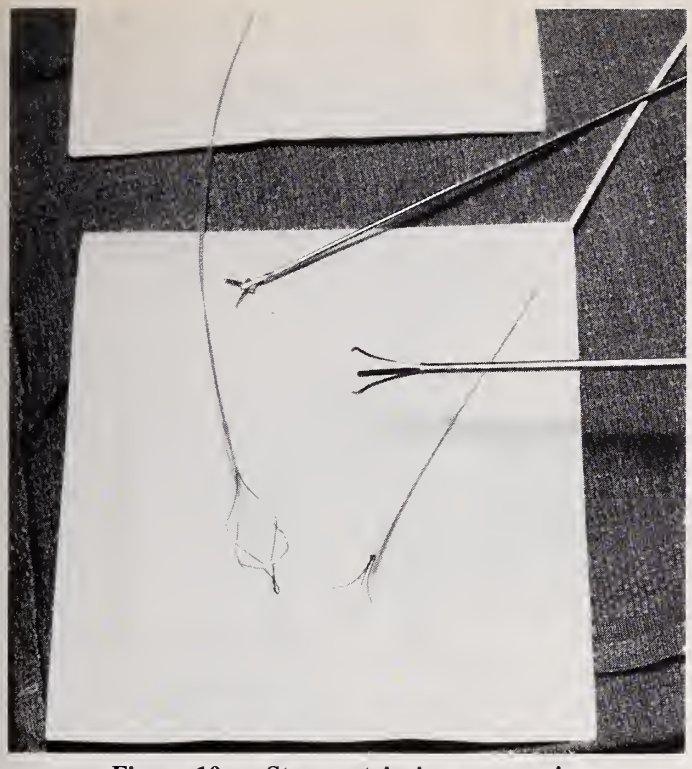


Figure 10 — Stone retrieving accessories

nificantly to operative time. Total hospital stay for simple cases is now averaging 3 days, with most patients able to return to their jobs in about 1 week. The average cost of the procedure should be less than previously due to a diminished hospital stay, with the overall net cost reduced even more by an earlier return to productive work.

Discussion

The practice and study of percutaneous urologic procedures using various radiologic and endoscopic techniques — endourology — is the current state of the art in urologic practice today. Our results, along with those of the aforementioned authors, have been very encouraging. With a complete set of endourologic equipment, i.e., radiologic accessories necessary for percutaneous access to the kidney, rigid nephroscope with ultrasonic lithotripter (Figure 8), flexible nephroscope with electrohydraulic lithotripter (Figure 9), and a various assortment of endourologic accessories such as balloon dilators, grasping forceps, ureteral stents, and stone baskets (Figure 10), the endourologist is able to remove nonsurgically many types of upper urinary calculi in various locations.

Though experience is being gained with time, the only stones which presently appear unapproachable by these techniques appear to be the larger staghorn calculi, severely imbedded ureteral calculi, and larger calyceal stones which may not be extractable with electrohydraulic lithotripsy. With further improvement in instrumentation, however, progress along these avenues may be made. In addition, diagnostic procedures such as pyeloscopy or ureteroscopy to evaluate filling defects seen on IVPs or retrograde pyelograms can be performed. One of our patients with a mild UPJ obstruction due to a high ureteral insertion underwent percutaneous incision of the UPJ. Obviously, time will tell how much can be performed percutaneously.

Acknowledgement

Most if not all of the present techniques employed were — and are still — being taught by the Department of Continuing Education, Urology and Radiology Department, University of Minnesota, Minneapolis, Minn. To them we are gratefully indebted.

Addendum

Since this paper was submitted in May, 1983, an additional 56 patients have undergone percutaneous removal of stones in the kidney and ureter. Successful removal of the offending stone was achieved in approximately 95% of these patients. In one other patient, we recently also removed approximately 95% of a large staghorn calculus percutaneously.

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PFR-040/83

The author reviews certain principles and approaches to the management of breast nodules.

Breast Nodules

WILLIAM E. MITCHELL, JR., M.D., *Atlanta**

No article about decision making can completely capture the complex process which takes place in a clinician's mind during evaluation of a breast nodule. Factors to be considered include the physical characteristics of the nodule, what previous mammograms/biopsies have shown, the patient's family history, previous breast problems, age and hormone status, and the likelihood of her adherence to recommended followup. Despite the complexities involved, certain principles and approaches to management can be suggested with the hope that readers will be stimulated to review the principles which they believe to be important in their own management of breast nodules.

Principles and Definitions

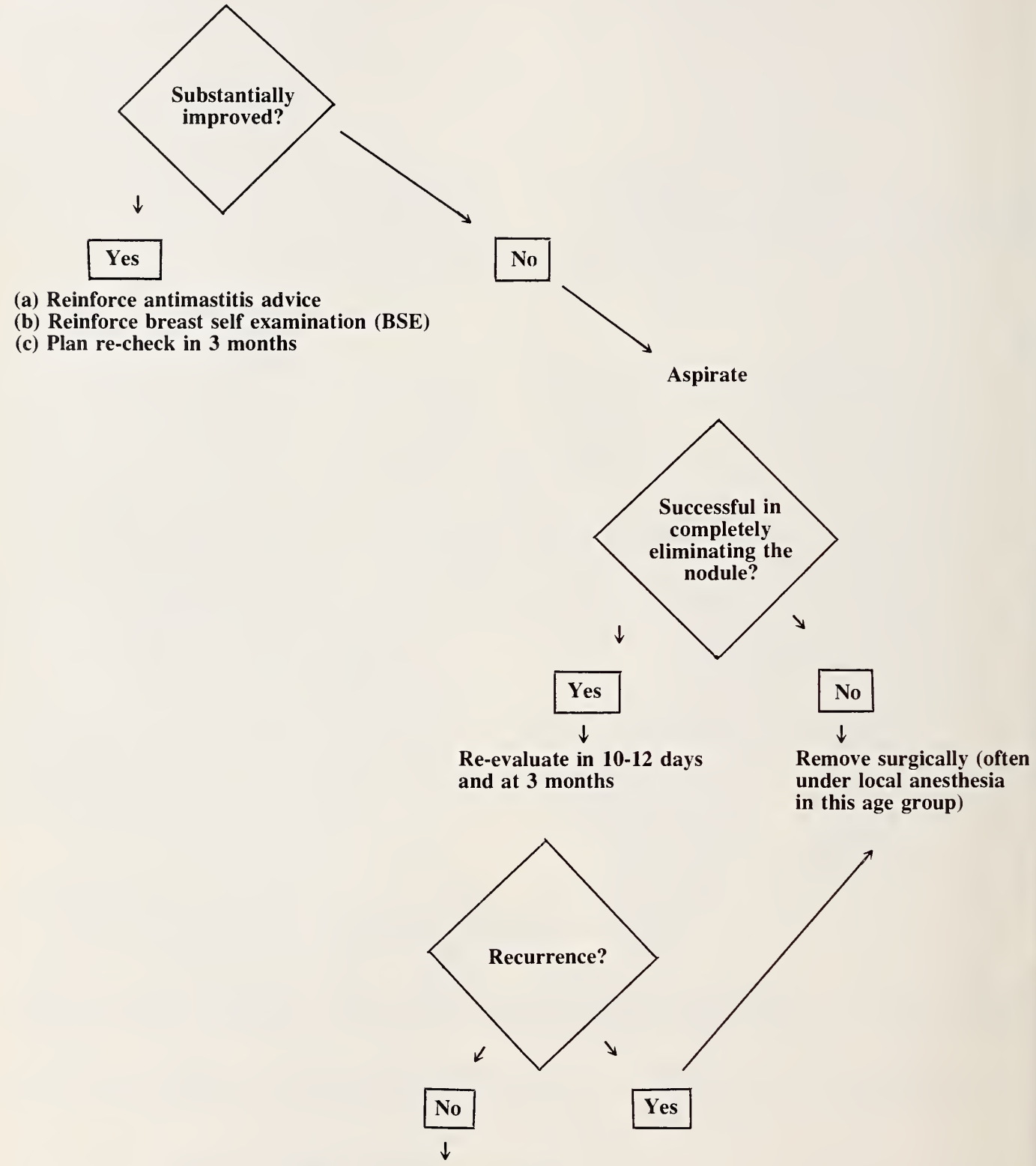
1. A "suspicious" nodule is one which feels suspicious to the examiner, behaves suspiciously under observation, or looks suspicious on mammogram/xerogram.
2. Nodules which feel hard (other than clinical fibroadenomas in women under 30 years of age), have irregular palpable edges, seem at all fixed to the skin (dimpling) or underlying fascia, are associated with nipple discharge, or have associated unilateral axillary nodes greater than 1.0 cm. in diameter must be considered suspicious, particularly if the patient is over 30 years of age.
3. All suspicious breast nodules should be removed promptly, occasionally by aspiration, usually by open biopsy.
4. Increased density of the breast tissue without there being a 3-dimensional nodule whose borders can be outlined is referred to as "thickening." Such thickening, often associated with pain or tenderness, is the most common presentation of mild fibrocystic disease and will usually vary in severity at different times of the monthly menstrual cycle. In fact, most women will have some transient breast thickening around the time of their menstrual periods and this finding alone probably does not warrant the sometimes frightening labels of "fibrocystic disease," or "cystic disease," unless it persists through several menstrual cycles.
5. Most non-suspicious nodules are benign and will disappear or subside considerably in 1 or 2 months, but a few will prove to be malignant, so early followup is essential.
6. Fibroadenomas are freely movable, firm, minimally tender, seen usually in women under 30 years of age, and can usually be removed under local anesthesia on an outpatient basis.
7. The major issue in deciding about biopsy of a dominant nodule which varies during the menstrual cycle is whether the nodule subsides completely in the intermenstrual phase, not how large it becomes at the time of the menses. A lump or thickening that subsides completely only to recur on a monthly cycle is virtually never malignant. Malignancies will occasionally *seem* to vary (probably due to changes in overlying fibrocystic disease) but they will not subside completely, and only rarely will they appear to diminish more than 20 per cent. Therefore, the failure of a dominant nodule to diminish significantly during a 1 to 2 month period of observation must be considered suspicious.
8. Mammograms/xerograms are never definitive but they are the "gold standard" among the

* Dr. Mitchell practices general surgery. Send reprint requests to him at 35 Collier Rd., NW, Ste. 710, Atlanta, GA 30309.

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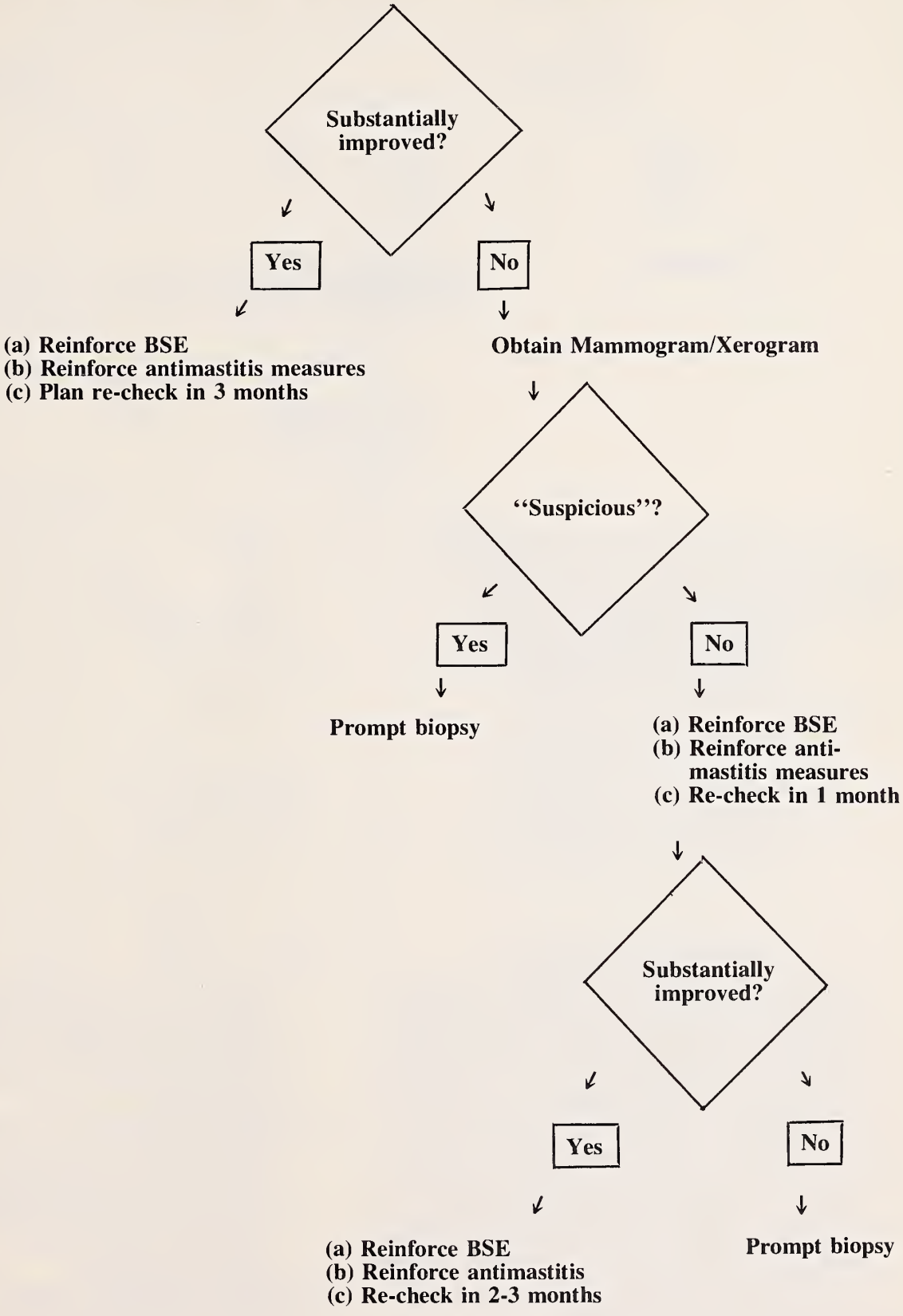
MANAGEMENT OF DOMINANT NODULE WHICH DOES NOT FEEL SUSPICIOUS — UNDER 30 YEARS OF AGE

1. Treat with conservative antimastitis measures (avoid caffeine and other methylxanthines, wear firm supportive bra, and use moderate doses of Vitamin E, such as 400-600 units daily).
2. Re-evaluate at time of least congestion — in approximately 2 months (e.g., 10-12 days after start of 2nd menstrual period).

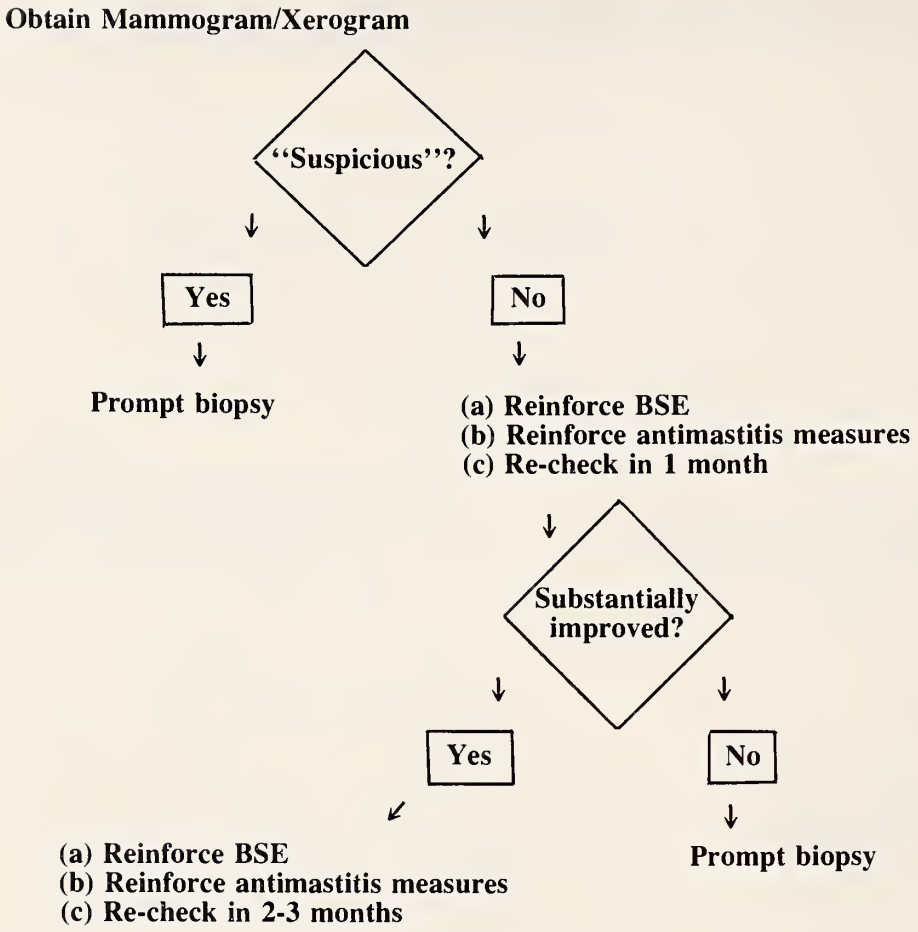


MANAGEMENT OF DOMINANT NODULE WHICH DOES NOT FEEL SUSPICIOUS — 30-40 YEARS OF AGE

1. Treat with conservative antimastitis measures (avoid caffeine and other methylxanthines, wear firm supportive bra, and use moderate doses of Vitamin E, such as 400-600 units daily).
2. Re-evaluate at time of least congestion (10-12 days after start of *next* menstrual period).



MANAGEMENT OF DOMINANT NODULE WHICH DOES NOT FEEL SUSPICIOUS — OVER 40 YEARS OF AGE



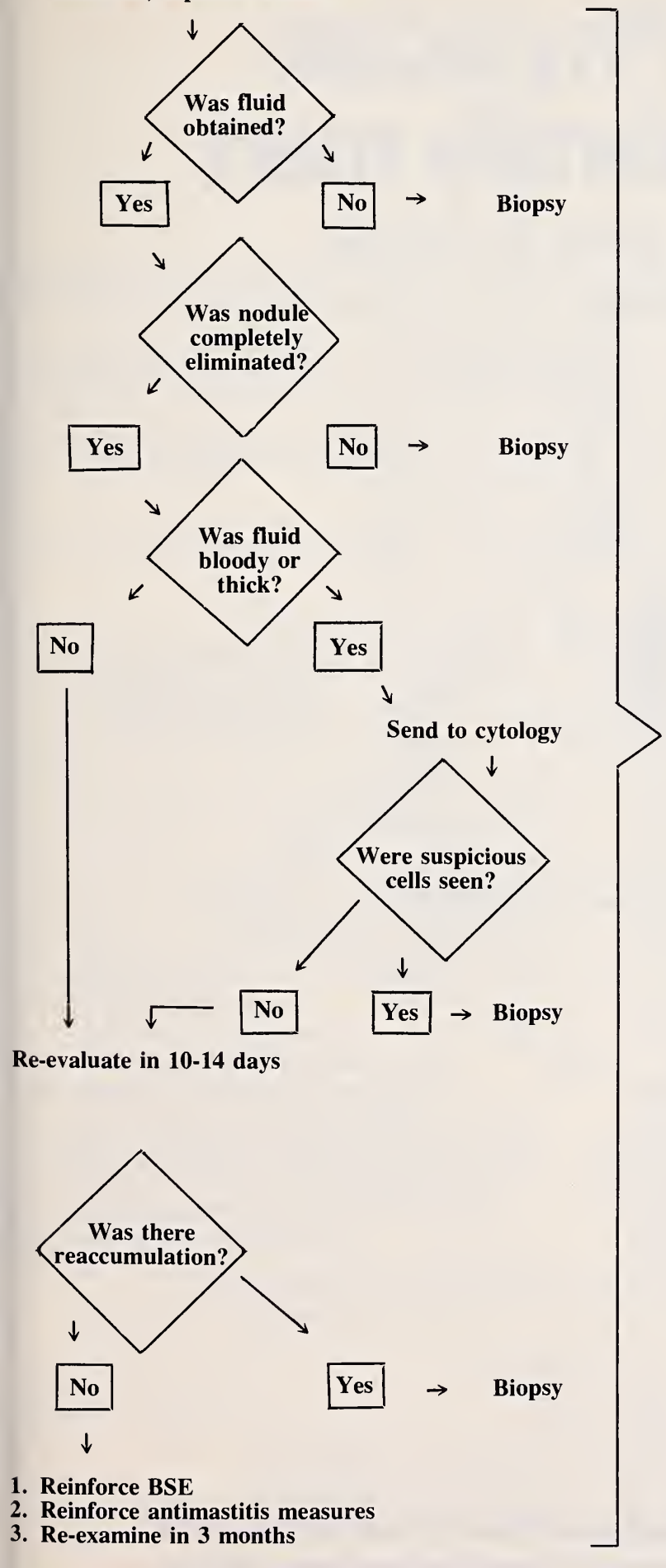
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non-invasive diagnostic studies. Ultra-sonography may be of considerable additional help, particularly in a woman with the dense type of breast tissue often seen before the menopause. Thermograms, diaphanography, and CT scans hold promise, particularly for screening purposes, but they are less reliable (i.e., less sensitive and less specific) than mammograms and xerograms. Current investigational studies suggest that a combination of modalities such as mammograms/xerograms and ultrasonography may increase overall accuracy, though only at considerable added expense.

9. A "negative" mammogram can provide some reassurance that a period of observation is appropriate in managing a non-suspicious area of thickening or nodularity, *but a negative mammogram is meaningless if a lump feels suspicious*. On the other hand, a "suspicious" mammogram warrants prompt biopsy even if the area in question does not feel suspicious to the examiner.
10. Biopsies should not be done without adequate indication because of the associated discomfort, cost, disability, and (perhaps most important of all), the scarring which makes subsequent examination of that area by the patient and physician more difficult.
11. BREAST SELF EXAMINATION — All primary care physicians and all surgeons treating breast disease should take time to be sure that their patients both understand the importance of, and can demonstrate, proper breast self examination (BSE).

DOMINANT, CLINICALLY SUSPICIOUS NODULE AT ANY AGE

1. Obtain mammogram/xerogram (since aspiration may distort architecture)
2. If suspicious, proceed to biopsy
3. Otherwise, aspirate nodule

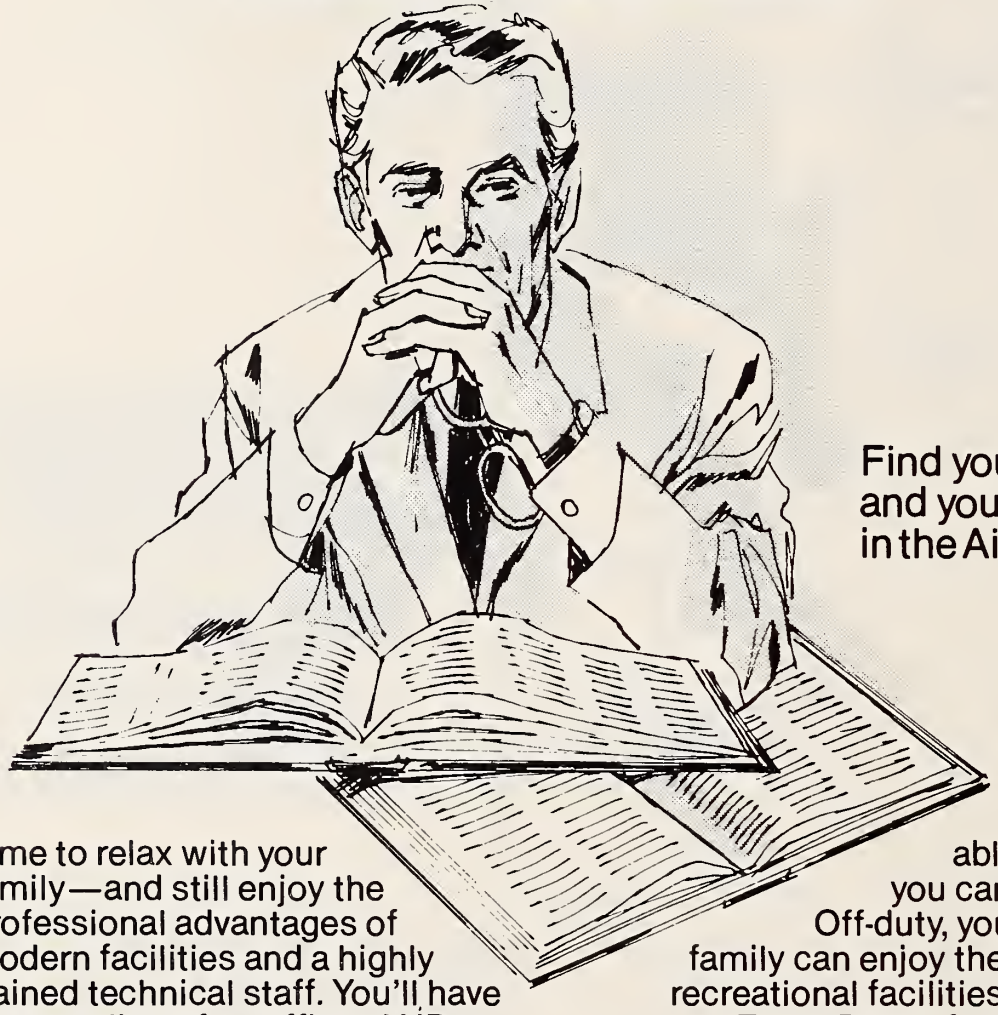


Depending on available facilities, the patient's age and health, level of suspicion, and preference of the patient and surgeon, various types of (and settings for) biopsies are feasible: e.g.

1. Needle biopsy under local anesthesia.
2. Outpatient biopsy under local anesthesia.
3. Outpatient biopsy under general anesthesia.
4. Traditional inpatient biopsy under general with "double set-up."

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In the high risk operative candidate, percutaneous transcatheter embolization should be considered.

Pancreaticoduodenal Artery Aneurysm: Nonoperative Management

STACY HARBIN, M.D., DAVID ROSENTHAL, M.D., THOMAS FULLER, M.D., PANO LAMIS, M.D., and PAUL E. STANTON, JR., M.D. *Atlanta**

Abstract

Operative intervention is the primary course of treatment for the more accessible, large splanchnic artery aneurysms. However, aneurysms of the smaller splanchnic arteries are infrequent, and only 25 cases of pancreaticoduodenal artery aneurysms have been reported.

In the high risk operative candidate or when the location of a parapancreatic artery aneurysm would make operation hazardous, percutaneous transcatheter embolization should be considered. A case of an inferior pancreaticoduodenal artery aneurysm managed by embolization is presented.

Introduction

Although aneurysms of the splenic and hepatic arteries have been reported with relative frequency, aneurysms of the small splanchnic arteries are infrequent, and only 25 cases of pancreaticoduodenal artery aneurysms have been cited in the literature.[1] This report details the nonoperative management of an inferior pancreaticoduodenal artery aneurysm.

Case Report

A 63-year-old white woman was admitted to Georgia Baptist Medical Center in Atlanta with the diagnosis of right renal artery aneurysm. The suspicion for a renal artery aneurysm was based upon a flat plate radiograph of the abdomen which demonstrated a curvilinear right upper quadrant mass, with a normal oral cholecystogram. The patient denied abdominal pain, nausea, or vomiting, and there was no history of pancreatitis, biliary tract disease, or abdominal trauma.

Physical examination was unremarkable, and admission laboratory values were normal.

Aortography with selective catheterization of the celiac and superior mesenteric arteries documented a 2 cm saccular aneurysm in the posterior branch of the inferior pancreaticoduodenal artery. The principal blood supply was derived from the superior mesenteric artery (Figure 1). Due to the retropancreatic location of the aneurysm, an attempt at percutaneous transcatheter embolization occlusion was indicated. The inferior pancreaticoduodenal artery was selectively catheterized, and Gellfoam plugs were wedged into the aneurysm. A small amount of contrast was extravasated, yet the patient offered no complaints, and her vital signs remained stable. The following day, repeat selective superior mesenteric arteriography demonstrated successful occlusion of the inferior pancreaticoduodenal artery aneurysm (Figure 2).

Discussion

Atherosclerosis is the major etiology of parapancreatic arterial aneurysms and accounts for more than 50% of cases reported in the literature.[1, 2] Chronic recurrent pancreatitis with or without pseudocyst appears to be the second most common cause, while trauma, surgery, penetrating duodenal

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Figure 1 — Aortography with selective catheterization of the superior mesenteric artery documenting a 2 cm saccular aneurysm in the posterior branch of the inferior pancreaticoduodenal artery.



Figure 2 — Selective superior mesenteric arteriography demonstrating successful occlusion of the inferior pancreaticoduodenal artery aneurysm.

ulcer, carcinoma of the head of the pancreas, and retroperitoneal tumor have all been indicted as etiologic factors.[3, 4]

Previous reports utilizing transcatheter embolization of parapancreatic arterial aneurysms have noted the fragility of these lesions and tendency to rupture during embolization.[5] Although no contrast extravasation was noted from the aneurysm itself during embolization, free contrast did extravasate from the proximal inferior pancreaticoduodenal artery, attesting to the fragility of the vessels in this area.

Although operative intervention remains the primary course of treatment for the more accessible and larger splanchnic artery aneurysms, percutaneous transcatheter embolization should be considered in the high risk patient or when the location of the aneurysm would make operation hazardous.

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The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly; repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

This statement urges continued vigilance to reduce further the morbidity and mortality associated with tuberculosis.

A Joint Statement of the Lung Associations and Tuberculosis Controllers of the Southeastern States*

Tuberculosis remains a significant public and personal health problem. It continues to require the special effort and attention of public agencies, lung associations, and private medical practitioners to ensure continued progress in reducing tuberculosis morbidity and mortality.

Representatives from the state health agencies and respective state lung associations of Alabama, Georgia, Florida, North Carolina, South Carolina, and Tennessee met in June, 1982, to discuss strengths and weaknesses of the various state programs. This meeting was called to exchange ideas in a format where tuberculosis control would be the *only* subject matter.

A second 2-day meeting was held in October, 1982, with additional representation of the state health agencies and lung associations from Kentucky and Mississippi. A committee was asked to formulate a statement reflecting state needs common to all in tuberculosis control.† Another meeting in approximately 6 months is being planned to examine the usage and results of this statement.

Joint Statement

Although significant progress has been achieved in the control of tuberculosis, it will not be eradicated for generations. Tuberculosis occurs unevenly throughout the United States. The Southeastern states have the highest incidence of tuberculosis of any geographical section in the country, with the case and death rates being significantly higher in the metropolitan areas, large cities, and in certain subpopulation groups. The Georgia and national tuberculosis case rates are illustrated in Figure 1.

A review of tuberculosis morbidity and mortality rates shows that the disease is no longer the "white plague" of the past. It is no longer among the top ten killers and cripplers of our society. These facts, associated with increased competition for federal, state, and voluntary funds, account in part for the de-emphasis of fiscal and other support of tuberculosis control throughout the country. The change from "in-hospital care" to "ambulatory care" and shortened but highly successful chemotherapeutic regimens have led to the misconception of public officials that tuberculosis is no longer a problem.

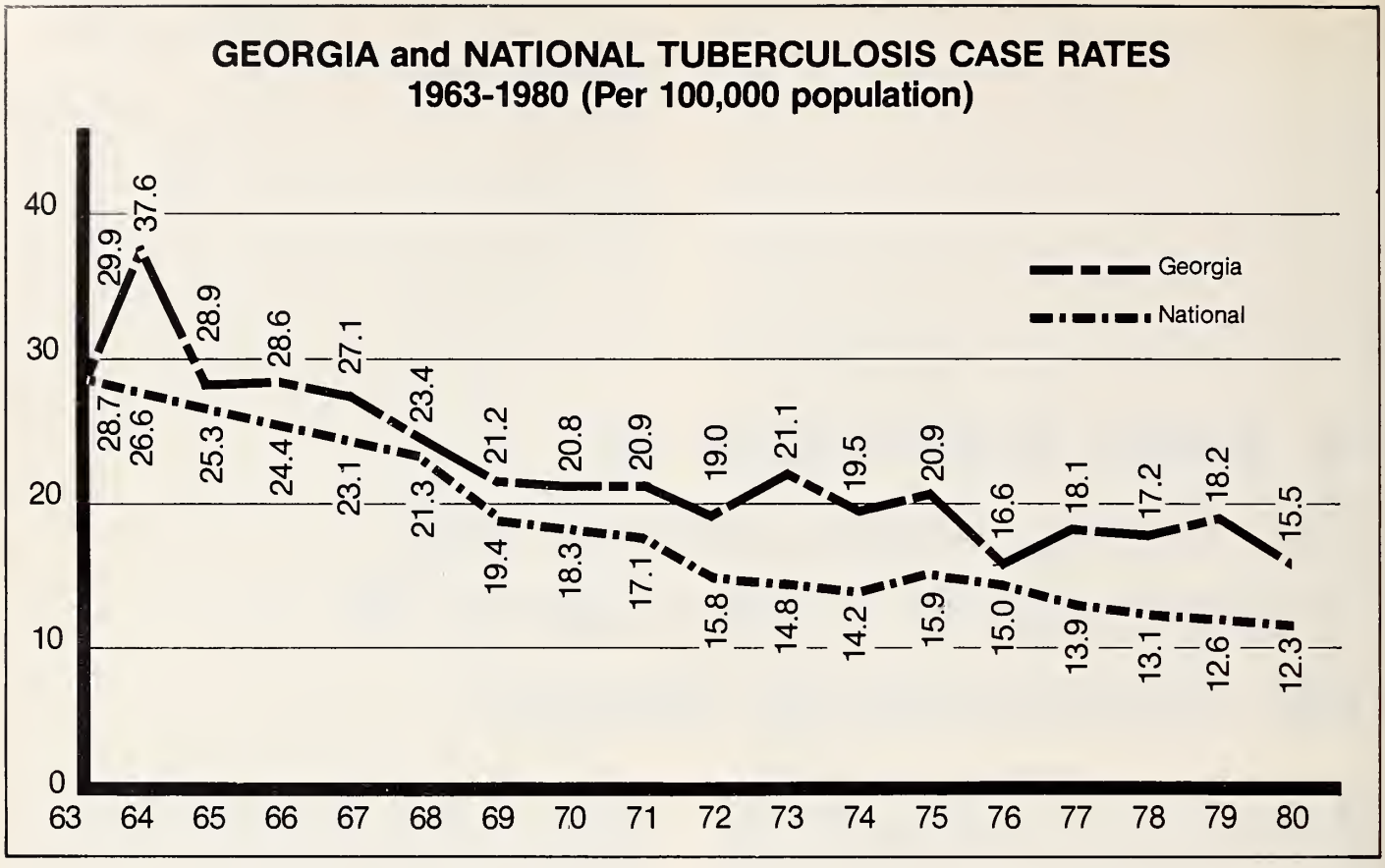
For the long-term downward trend in tuberculosis occurrence to continue, the following minimum priorities should be encompassed in each state program.

1. *A statewide centralized program*
 A central state tuberculosis control unit must be responsible for formulating and directing the overall mandates, policies, rules, and regulations of each statewide program. There must also be similar units in the larger cities and metropolitan areas which operate in unison with the state program. Without specific control units to intensify

* Adopted at the 1982 Southeastern States Tuberculosis Conference. Send reprint requests to Gerald W. Staton, Jr., M.D., Chairman, Publications Committee, Georgia Thoracic Society, 25 Prescott St., NE, Atlanta, GA 30308.

† Committee members include Chairman, Raymond F. Corpe, M.D., Georgia Department of Human Resources; William Tally, M.D., Alabama Medical Coordinator; Robert Gorske, Florida Health Program Specialist; Stephen Willcox, Florida American Lung Association; and Pattie Stanley, North Carolina American Lung Association.

FIGURE 1



GEORGIA'S TB PROGRAM
ANNUAL REPORT — 1980
DEPARTMENT OF HUMAN RESOURCES

application of available technology, essential components of tuberculosis surveillance, assessment, and containment will become fragmented, resulting in excessive and unnecessary future expenditures.

2. *Comprehensive statewide data systems*
Data systems which accurately define the tuberculosis problem within the states are essential. A chemoprophylaxis register is the natural offshoot of a computerized case contact investigation register showing close contacts who are actually ill with the disease, those who need preventive therapy, and those who are not infected. All of these data must be integrated in a statewide, medically directed program. This information must reach each local tuberculosis control program in a regular, timely fashion to ensure proper drug therapy, to assess compliance, and to monitor patients under supervision. The Arden House Conference on Tuberculosis was held at Harriman, New York, in 1959. "The Goals and Standards for Eliminating Tuberculosis," a statement of the committee appointed by the United States Public Health Service and published in the NTA Bulletin of November, 1960, is the basis of current national and state goals and standards. As a minimum requirement, these data systems *must* address the immediate goals and program performance standards relating to case detection and service to patients undergoing treatment for tuberculosis. Each state must be capable of furnishing these data to the United States Public Health Service and to local tuberculosis control units at least on a yearly basis.

3. *Personnel*
Each state and major city control unit must have knowledgeable staff personnel to analyze and employ these comprehensive data. There should be detailed, intricate statistical information on tuberculosis, both from medical and sociologic standpoints, available to program management for correlation, guidance, and redirection of each state's program. Fiscal responsibility and accountability for the program must be vested in these management groups.

A specialized core of workers is essential to maintain accountability and effectiveness in tuberculosis control. Tuberculosis control efforts would only be further aggravated through conflicting priorities of a more generalized staff approach.

4. *Full use of established methods to treat tuberculosis*
 The methods needed to properly treat and prevent tuberculosis are well documented in the medical literature. A successful tuberculosis control effort will require each state to fully utilize the most current acceptable therapy available and to work closely with local physicians who have an interest in tuberculosis control. Each state must have the staff and funds necessary to implement current methods and must concentrate on two areas of tuberculosis control: (1) adequate treatment of known cases; and (2) contact investigation and preventive treatment when indicated.
5. *Advocacy of tuberculosis control*
 There must be renewed advocacy of tuberculosis control. The American Lung Association for many years provided outstanding advocacy and support in the battle against tuberculosis. However, during the past few years tuberculosis control has been relegated to a lower priority of the Association. This has contributed to complacency about tuberculosis control by physicians, health officials, government officials, and the general public. This advocacy must be clearly re-established within the national and state lung associations and in each state's official health organization. Without strong advocacy, including the leadership role by lung associations at all of the above levels, the tuberculosis control movement will suffer from inefficiency, fragmentation of activities, lack of accountability, and future unnecessary costs to control and eradicate this disease.

Disciplinary Actions of the Composite State Board of Medical Examiners

The following is a summary of Board actions for calendar year 1983 to date. Names, license numbers, addresses, and summaries of disciplinary actions will be published for all public actions.

Consent Orders — 15
Suspensions — 1
Voluntary Surrenders — 4

Consent Orders are generally disciplinary actions where the physician and the Board agree to a disciplinary sanction without a hearing. These sanctions typically include conditions of probation and monitoring by the Board; they may also include suspension. There are presently 24 physicians on probation with the Board; this action is enforced through a Consent Order.

Some characteristics of Consent Orders issued since January 1, 1983 include:

Total years of probation — 36
Schedule II & II-N restrictions — 10
Suspension (months) — 13
Continuing education required (hours) — 230

A Voluntary Surrender is a disciplinary action where a physician agrees to surrender his license rather than go through with a hearing.

Orders of the Board are public documents unless otherwise stipulated; copies may be obtained from the Board. Complaints, patient records, and the results of any investigation whatsoever shall be reported only to the Board, and the records of such investigations shall be kept by the Board; no part of any such records shall be released for any purpose other than a hearing before the Board; nor shall such records be subject to subpoena.

(Reprinted from the Newsletter of the Composite State Board of Medical Examiners, June, 1983.)

If someone asked you for directions to Valley Psychiatric Hospital could you be of assistance?

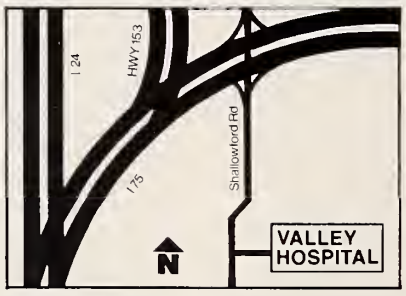


"Having the need for psychiatric treatment is not the tragedy . . . having the need and not knowing where to turn for help is."

VALLEY PSYCHIATRIC HOSPITAL

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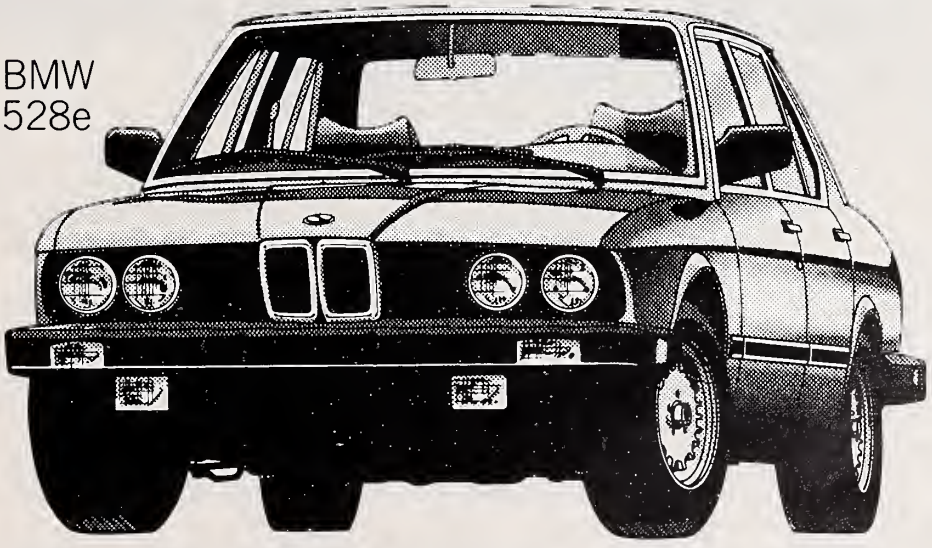
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Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located twenty minutes north west of downtown Atlanta.

The hospital offers four separately housed programs in adult and adolescent chemical dependency and adult and adolescent psychiatry.

Award winning in its architectural design, Ridgeview is housed on 40 acres of land with lighted tennis and volleyball courts, swimming pool, and a fully equipped gymnasium for supervised sports and physical education programs.

Adult Chemical Dependency

The Adult Chemical Dependency Program offers a unique and innovative treatment modality that includes inpatient treatment and an emphasis on aftercare. The staff views alcohol and drug dependency as a primary disease that affects a person physically and psychologically.

The seven element program includes medical, educational, and family therapy, Alcoholics Anonymous and Narcotics Anonymous, group psychotherapy, non-chemical coping skills and spiritual counseling.

Adult Psychiatric Treatment

The Adult Psychiatric Program at Ridgeview provides specialized treatment for persons suffering from depression, anxiety, schizophrenia, manic-depressive disorders, personality disorders, and other similar dysfunctions.

Under the psychiatrist's leadership, treatment is specifically designed for each patient's particular needs in order to promote a productive return to family, job, and community as early as possible.

Adolescent Treatment Services

The Adolescent Chemical Dependency Treatment Program is based on the belief that adolescent chemical dependency is a chronic, progressive primary disease which affects the physical, psychological and sociological aspects of the life of the adolescent and his/her family.

The Adolescent Psychiatric Treatment Program provides an opportunity for building self-esteem and learning to deal with responsibility. A full range of modern therapies aid in resolving the complex emotional, behavorial, and educational difficulties of the adolescent, including individual, group, family, occupational, and recreational therapies.

Ridgeview INSTITUTE

3995 South Cobb Drive
Smyrna, Georgia / (404) 434-4567

ANNOUNCING TWO NEW ROCKERS FROM THE ROCKER SHOP[S.M.]

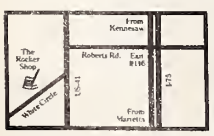
The Melson Standard Rocker and the Melson Basic Rocker. Both set a standard for superior quality. At the Rocker Shop we construct each and every one of our magnificent traditional rockers entirely by hand with tools and techniques that probably can't even be found anymore... except perhaps in museums. From the hand balancing of each rocker through the hand weaving of cane seats and backs to the final assembly and hand sanding, each chair is created to a standard set many years ago.

The materials used in our rockers are as fine as the skills that go into making them. In an era of labels reading "wood products" or "plastic laminates" each of our rockers and accessories is made of beautiful mature oak, selected with painstaking care from an ever-diminishing supply. We both kiln dry and air dry this fine oak, then blend the two for strength and flexibility. The cane used in our double-woven seats and backs is the finest available for comfort and durability. And, if that cane isn't available, we simply stop making our chairs till the next harvest comes in.

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In vitro studies demonstrate

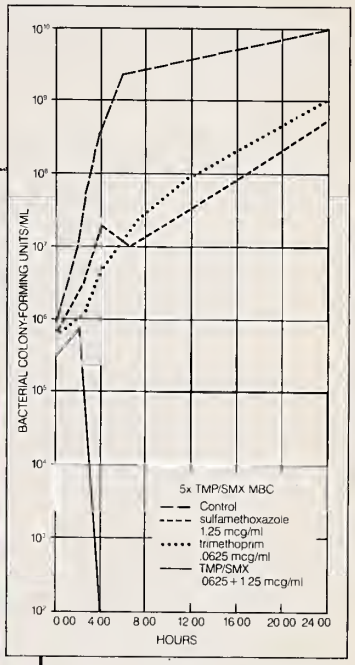
Bactericidal activity with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus sp.*	*Enterobacter sp.*	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofur-antoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI* *



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro*.[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J *et al: Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Iravani A *et al: Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category *C*. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: *Not recommended for infants less than two months of age.*

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

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Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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Please see PROCARDIA *brief summary on adjoining page.*

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J-9043-4 July 1981

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Blood Transfusion, Blood Donation, and AIDS

The American Red Cross Blood Services serving Georgia (Atlanta, Savannah, Mobile) has taken steps in concert with the National Red Cross and other national blood collection organizations in response to the potential risk of transfusion-associated AIDS (acquired immune deficiency syndrome). Working together, and in compliance with the recommendations of the FDA's Office of Biologics, we initiated educational programs to inform potential donors of the known high risk groups and developed procedures for excluding blood donations from individuals in these high risk groups.

The number of cases of AIDS reported to the Centers for Disease Control in Atlanta has increased to 1552. However, 94 percent of these cases remain within the four known high risk groups: homosexual or bisexual males with multiple sex partners; intravenous drug abusers, recent entrants from Haiti, and persons with hemophilia. Only one newborn infant and 14 adult recipients of blood transfusions have been identified as cases of possible transfusion-associated AIDS. At this time, we estimate that the possible risk of transfusion-associated AIDS is on the order of one case per million patients transfused.

The public remains concerned about AIDS and the risk of transmitting AIDS by blood transfusion. One consequence of the understandable, but excessive, concern for transfusion-associated AIDS has been requests by patients and their physicians to have blood donors selected from family members, friends, co-workers, and even newly formed private donor clubs. These "directed donations" are assumed to be safer than those available through community blood banks, although there is no evidence to support this notion.

The American Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers have issued a joint statement strongly recommending that such directed donation programs *not* be conducted.

Some "donor specific" programs have a sound scientific basis. For example, a donor may be selected for a platelet, white cell, or rare blood transfusion for a patient because the donor's blood type is needed to match the recipient's. In these cases, transfusions from family members, particularly twins, brothers, and sisters, may be ideal. Also, predeposit of the patient's own blood for a future transfusion during surgery, e.g., "autologous transfusion," may be a suitable procedure for selected patients needing rare blood types. Autologous donations also eliminate the risk of certain diseases known to be transmitted by blood, such as viral hepatitis. However, "directed donations" based on social criteria are different from "donor specific" and autologous donations and do not provide the benefits of these programs.

The concept that family members and selected friends will provide safer blood is unproven and unrealistic. These same individuals are and have been the nation's volunteer blood donors who have, in the past, given freely to the community rather

than to a particular individual. There is no reason to think that segregating these individuals into selected donor panels will increase safety to the community's blood supply. In addition, a system of directed donation may create intense pressures on family and friends who may therefore be untruthful about their health histories in order to maintain confidentiality of personal information. It is possible that the administrative and operational complexity that will be part of any widespread application of directed donations may lead to a significant increase in clerical errors and, in this way, reduce the safety of transfusion.

The American Red Cross Blood Services does not provide "directed donations."

Finally, there is the risk that widespread attempts to direct donations, while not increasing the safety of transfusions, will seriously disrupt the nation's blood supply. Volunteers are essential for meeting our nation's needs for blood and blood products. There is a real concern that donors may refrain from routine blood donations while awaiting requests to provide directed donations and, thereby, could disrupt the blood supply to the point that emergency and even some routine needs for transfusions may go unmet.

Given these considerations, the American Red Cross Blood Services does not provide "directed donations." We reaffirm our commitment to a safe blood supply for all recipients, to maintaining the highest standards possible for selecting healthy volunteer donors, and to strict compliance with pertinent recommendations by the United States Public Health Service and other federal regulatory bodies.

We appreciate your understanding and support as we work together to maintain an adequate and safe blood supply in our community.

Alfred J. Grindon, M.D., Atlanta
Jane B. Jennings, M.D., Savannah
*George M. McCullars, M.D., Ph.D., Mobile, AL**

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Genitourinary Tumors I: Carcinoma of the Bladder

SAM D. GRAHAM, JR., M.D., *Atlanta**

CARCINOMA OF THE URINARY BLADDER in 1983 will account for 9% of all solid tumors in males and 4% of all solid tumors in females. This tumor will also account for 10,700 deaths in 1983.[1] Despite newer therapeutic modalities, the estimated 5-year survival from carcinoma of the bladder has not changed appreciably since 1960.[1] As with most urologic tumors, the preponderance is in the elderly (over age 60) and in the male.

Most urothelial malignancies in the United States are transitional cell carcinomas. These comprise approximately 90% of all bladder cancers, with squamous cell (5%) and adenocarcinoma (3%) making up the remainder of primary neoplasms of the bladder. Approximately 70% of these tumors are exophytic, papillary, and non-infiltrating, with a concomitantly favorable prognosis. Twenty percent of all tumors will be papillary lesions infiltrating the bladder wall, and the remaining 10% will be sessile with deep infiltration.

The treatment of carcinoma of the bladder is determined by the initial stage of presentation which is directly correlated to ultimate prognosis. Stage O lesions are confined to the basement membrane (Table 1). These carry the best prognosis and usually are very low grade. Stage A lesions invade lamina propria but do not invade the muscle. Stage B lesions invade the bladder musculature, and it is at this point that survival drops significantly. Stage C lesions and Stage D lesions show progressively worsening prognoses with advancing stage.

Recently, increasing attention has been focused on carcinoma *in situ*. This pathologic diagnosis connotes a much more aggressive tumor than has been previously suspected. For example, carcinoma *in situ* associated with a papillary tumor denotes an 85% chance of invasion within 2 years.[2, 3] One series showed that

TABLE 1 — Stage of Presentation of Carcinoma of the Bladder

Stage	*Depth of Invasion*
O	Non invasive
A	Lamina Propria
B-1	Muscularis — Superficial
B-2	Muscularis — Deep
C	Through Bladder Wall
D-1	Local Metastases
D-2	Distant Metastases

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Prepared at the request of the Georgia Division, American Cancer Society.

TABLE II — 5-Year Survival Rates of Patients With Carcinoma of the Bladder, By Stage and Treatment Modality

Stage	*TURBT + Repeat Cystoscopy*	*Cystectomy Only*	*Pre-op Radiation + Cystectomy*	*Radiation Only*
O	95%			
A	70%			
B-1		50%	50%	8-18%
B-2		9-26%	45-50%	
C		4-20%	33-45%	
D				0-14%

patients with carcinoma *in situ* associated with a noninvasive papillary tumor had a 5-year mortality rate of 57%. Carcinoma *in situ* associated with a history of bladder malignancy will exhibit a 40% chance of invasion, and in patients where cancer *in situ* is found as an isolated phenomena, 13% will progress to invasion.

Presenting symptoms of carcinoma of the bladder are primarily hematuria (75%), urinary tract infection (30%), and vesical irritability (30%). Vesical irritability is frequently associated with invasion probably due to irritation of the bladder muscle. Other symptoms such as rectal obstruction, pelvic pain, and lower extremity edema are usually associated with widespread disease.

The initial workup of the patient with gross painless hematuria should include an intravenous pyelogram and cystoscopy. Frequently, the intravenous pyelogram will not reveal the bladder tumor, since typically these are too small to be seen on the cystographic phase of the IVP. However, with the IVP, one may rule out associated upper tract urothelial tumors as well as stage the tumor. Ureteral displacement may be due to enlarged lymph nodes, and ureteral obstruction may be associated with Stage C bladder tumors. Cystoscopy usually reveals a small papillary lesion which may be single or multiple. If a lesion is seen, it is transurethrally resected, both for treatment and staging. Biopsies are taken from the right, left, posterior, and anterior bladder walls and the prostatic urethra, where there appears to be normal mucosa, to rule out carcinoma *in situ*. Urinary cytologies have also proven to be of great benefit both in diagnosis and in follow up of patients with bladder carcinoma.

Further urologic workup is predicated on the extent of invasion of the primary tumor. If the primary tumor is Stage O or A, patients are frequently followed with repeat cystoscopies and cytologies every 3 months for 2 years. This is then extended to every 6 months for 3 years. If there is evidence of muscular invasion, however, one must consider more radical therapy. An adequate workup should include chest x-ray and abdominal-pelvic CT scan. The latter study is quite useful in localizing peri-aortic adenopathy and delineating liver metastases. The use of CT scanning may also be helpful with large exophytic tumors to help diagnose the extent of the bladder wall invasion. Further workup may include bone scan. We have not found lymphangiography to be of any more benefit than CT scanning in the diagnosis of lymphadenopathy.

The treatment of carcinoma of the bladder varies from stage to stage. As noted above, Stage O and A can usually be managed successfully with transurethral resection or fulguration of the tumors. These patients are followed with repeat cystoscopies and cytologies. For the Stage B lesions involving bladder muscle, the therapeutic recommendation is for radical cystectomy. Considerable controversy has existed as to whether preoperative radiation therapy, either 2000 rads in 1 week or 5000 rads in 5 weeks, is necessary. Despite the original enthusiasm, many centers, including ours, are reserving radiation therapy for patients with deep B or possible C lesions. The use of radiation therapy in patients with superficial B lesions does not appear to have any impact upon survival.[4, 5] However, with the deeper lesions, survival is markedly enhanced (Table 2). The operation of choice is radical cysto-prostatectomy with bilateral pelvic lymphadenectomy in males and

anterior pelvic exenteration in females. The decision to do a urethrectomy in males is based on the presence or absence of tumor into the prostatic urethra. Should the urethrectomy not be carried out at the initial procedure, the patient should be followed with urethral irrigations for cytology every 3 months.

Patients found at surgery to have C lesions or D lesions may be treated postoperatively with either radiation or chemotherapy. One must keep in mind, however, that once the surgery has been done, the intestines become fixed in the pelvis, making radiation much more hazardous due to the possibility of radiation-induced enteric fistulae.

Currently, the most effective drug for chemotherapy for carcinoma of the bladder is Cisplatinum.[6, 7] There does not appear to be any additive effect of giving Cisplatinum in combination with other drugs such as Adriamycin or Bleomycin. Intravesical chemotherapy with thiotepa or Mitomycin C is reserved for multiple or recurrent tumors, or patients who have CIS on bladder biopsy.[8] (Intravesical chemotherapy in the latter group is only moderately successful and is not recommended if the CIS is extensive.)

Results of treatment of carcinoma of the bladder show approximately 75% survival of Stage O and A. Stage O alone may have up to 95% survival. Stage B carcinomas have a 5-year survival of 30-40% with radical cystoprostatectomy. Patients with Stage C experience a 5-year survival of 20-30%, while patients with Stage D-2 disease have a 0% 5-year survival. A subset of patients with "minimal nodal disease" meaning one or two positive nodes, however, may be salvaged with up to 20% 5-year survival. Patients with Stage D-2 disease have a 0% 5-year survival.

The primary effort in the treatment of urothelial malignancies at present has been directed toward earlier detection and prediction of invasion. At present, there are several prognostic factors which would indicate patients at greater risk to develop invasion from previously superficial tumors. Initial clinical presentation is a fair prognostic indicator. If the initial tumor is non-infiltrating and papillary, a recurrence rate of 50% can be expected. The size of the initial tumor and multiplicity likewise are directly correlated to recurrence and invasion. Of all patients with initial single papillary lesions, 4% will later progress to invasion, while multiple tumors are associated with a 40% invasion risk. Further factors which may segregate those patients at risk for invasion versus those not at risk include cellular morphometry, cell surface antigens, urinary markers and associated carcinoma *in situ*. The presence of carcinoma *in situ,* as noted above, is associated with up to 85% chance of invasion. Pathologic grade has been also investigated as a predictor. Patients with Grade I carcinoma have a 71% 5-year survival for all stages, while patients with Grade III have a 37% 5-year survival. The use of fluorescence activated cell sorting (FACS) and the use of computer assisted cellular morphometric analysis may make the grading systems much more objective.[9] A third indicator of prognosis is the presence or absence of cell surface antigens. As with all cells within the human body, the blood group antigens A, B, or H, are expressed on the normal bladder epithelium. These antigens can be demonstrated on cut sections of the tissue by attaching the appropriate antibody with an indicator. Indicators include red blood cells, immunoperoxidase, and fluorescein labelled antibodies.[10] Patients with Stage A tumors will demonstrate the ABO antigens in 75% of the cases. Patients with invasive tumors are almost universally antigen negative. Only 8% of patients with pathologic Grade I or II tumors which express the blood antigens will develop invasion, while loss of antigens in low grade stage tumor has a high risk of invasion. At present, treatment of bladder cancer is primarily surgical. Newer modalities such as efforts to enhance immunologic responsiveness or possible new chemotherapeutic agents may help reduce the incidence of disease. It is hoped that by earlier detection of disease and better prognostic indicators that a significant impact can be made upon the ultimate survival of all patients.

(References listed on page 653.)

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Compensating a Spouse in a Divorce Proceeding for Providing Support and Funding During Medical School: A Review of Recent Judicial Approaches

ROBERT P. MONYAK, *Atlanta**

IT IS BECOMING a common scenario: the newlywed wife[1] of a prospective physician foregoes her own opportunities for higher education or training and works, helping put her husband through medical school. After the husband gets his medical degree or license, the marriage sours, ending in divorce. As part of the divorce settlement, the wife asks for a portion of the value of her husband's medical degree.

This unfortunate, but increasingly widespread situation has created a difficult legal issue: should a wife who helped pay for her husband's medical education be entitled to share in the benefits of the resultant degree in a divorce settlement? This issue is not easily resolved because there are equities on both sides. On the one hand, it seems unfair to force the husband to share the product of his individual talent and a lifetime of study with someone who simply paid for part of his support and education. On the other hand, "[m]arriage should not be a free ticket to professional education and training without subsequent obligations."[2]

Georgia courts have not yet been confronted with this difficult question. Moreover, courts in other states have not agreed on one answer; instead, the decisions to date suggest that at least three alternative approaches are available: First, a number of courts have reimbursed the wife, at least in part, for her contributions to her husband's education.[3] Second, some courts have allowed an award that reflects the change in the husband's and wife's potential for future earnings resulting from the wife's contributions.[4] Finally, at least one court has refused to award anything.[5] These approaches are discussed in more detail below.

Reimbursement

The courts that have reimbursed the wife for her contributions to her husband's medical education and support have done so to varying degrees and for different reasons. In *Inman v. Inman*,[6] a Kentucky court considered the husband's medical license to be marital property — in essence, no different from a house or stereo — and therefore subject to division. According to the court, the best way to value the wife's interest in this property was to measure her monetary investment. Thus, the court awarded the wife the amount she contributed for "direct support and school expenses during the period of education, plus reasonable interest and adjustments for inflation. . . ."[7]

* Prepared at the request of the Medical Association of Georgia. Mr. Monyak is a student at Duke Law School and is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

Most courts, however, have not considered a medical license to be marital property. In their view, a medical license

> "cannot be assigned, sold, transferred, conveyed or pledged. An advanced degree is a cumulative product of many years of previous education, combined with diligence and hard work. It may not be acquired by the mere expenditure of money. It is simply an intellectual achievement that may potentially assist in the future acquisition of property. In our view, it has none of the attributes of property in the usual sense of that term."[8]

Nonetheless, these courts have also justified reimbursement to the wife on a number of different grounds. For example, in *Hubbard v. Hubbard,*[9] the court based its award on the desire to avoid the unjust enrichment of the husband that would occur if the wife received nothing. Alternatively, courts have held that reimbursement is necessary for an "equitable" split of conventional marital property; in other words, although a medical degree is not property, it must be considered when determining what is a fair division of property.[10] In *In re Marriage of Lundberg,*[11] the court based its reimbursement award on the Wisconsin legislature's intent behind its divorce statutes that "a spouse who has been handicapped socially and economically by his or her contributions to a marriage shall be compensated for such contributions at the termination of the marriage."[12] Another court justified reimbursement on traditional equity grounds, focusing on the reasonable expectation of the wife that she would eventually share in the fruits of her investment.[13] Finally, in *Mahoney v. Mahoney,*[14] the court based reimbursement to the wife on the unfairness created when the husband's increased potential for future earnings was brought about by the wife's decrease in her potential because of her contributions.

Generally, the courts that award reimbursement, for whatever reasons, award the wife the amount of her money contributions to her husband's support and medical education. Often this amount is adjusted upward for interest and inflation.

Awards Reflecting Change in Potential for Future Earnings

A few courts have approached the problem from a different angle, taking the view that the appropriate remedy is not to reimburse the wife for what she spent, but rather to award her a share of the value of what her money accomplished — a share of the value of her husband's increased potential for future earnings. The court in *In re Marriage of Horstmann,*[15] for example, held that while a professional degree was not marital property subject to division, the husband's "potential for increase in future earning capacity made possible by the [professional] degree . . . conferred upon the husband with the aid of his wife's efforts" *did* constitute a divisible marital asset.[16] Although the court awarded a sum equivalent to reimbursement (because the wife valued the asset as her contributions to her husband's support and professional education), the court also pointed out that "other methods" could have been used. Unfortunately, the court did not elaborate on the alternative methods by which a wife could value such an intangible asset as her husband's "potential for increase in future earning capacity."

In a similar decision, the court in *Wisner v. Wisner*[17] reasoned that the wife's foregoing her own educational opportunities, thereby decreasing her potential for future earnings by contributing to her husband's medical education, justified her right to share in his resultant increased earning capacity. Unlike the usual scenario, however, the couple did not divorce until 7 years after the husband entered private practice. Because of this, the court held that whatever right to share the wife possessed was already adequately reflected in her other awards of community assets and maintenance. The wife, therefore, did not receive a separate award. The court, however, did note that a divorce occurring more quickly after the husband received his degree and before the couple had time to convert his earning capacity into tangible divisible assets would give the wife the right to share in her husband's future earning capacity.

No Award

Not all courts have consistently provided for an award to the wife. In fact, at least one court has flatly refused to make any award to a wife who had contributed to her husband's professional education. In *In re Marriage of McManama,*[18] the court was required to analyze an Indiana divorce law which dictated that any award above the value of the marital assets was a form of maintenance which could not be made unless the recipient demonstrated some physical or mental incapacity (such as an injury making it impossible to work). The court found that a professional degree was not marital property; as a result, because the wife had shown no incapacities, the court made no award to the wife for her contributions.

Conclusion

In total, recent cases in other states suggest that a number of alternative approaches will be available to the Georgia courts when they ultimately face the question whether a wife may recover in some way in a divorce proceeding for her contributions to her husband's medical education. As one possibility, Georgia courts might adopt the majority approach and allow the wife to recoup her contributions to her husband's support and educational expenses while in medical school. Alternatively, Georgia courts might be persuaded to use the minority rule and try to allocate to the wife the value of the increase due to her contributions in her husband's future earning potential. As a third alternative, Georgia courts might simply refuse to provide for any award. Finally, as they have done in other areas of the law (e.g. wrongful death actions involving unborn children), Georgia courts may choose to fashion their own approach to resolving this issue.

Notes

1. The term "wife" is used for the sake of convenience. Although no court has yet considered a case in which the husband was the nonphysician spouse, the considerations should be the same.
2. *Mahoney v. Mahoney,* 453 A.2d 527, 535 (N.J. 1982).
3. *See, e.g., Mahoney v. Mahoney, supra; Lynn v. Lynn,* 453 A.2d 539 (N.J. 1982); *In re Marriage of Lundberg,* 318 N.W.2d 918 (Wis. 1982); *DeLa Rosa v. DeLa Rosa,* 309 N.W.2d 755 (Minn. 1981); *Hubbard v. Hubbard, 603 P.2d 747 (Okla. 1979); Leveck v. Leveck,* 614 S.W.2d 710 (Ky. Ct. App. 1981); *Frausto v. Frausto,* 611 S.W.2d 656 (Tex. Ct. Civ. App. 1981); *Inman v. Inman,* 578 S.W.2d 266 (Ky. Ct. App. 1979).
4. *See, e.g., In re Marriage of Horstmann,* 263 N.W.2d 885 (Iowa 1978); *Wisner v. Wisner,* 631 P.2d 115 (Ariz. Ct. App. 1981); *Daniels v. Daniels,* 185 N.E.2d 773 (Ohio Ct. App. 1961).
5. *In re Marriage of McManama,* 339 N.E.2d 371 (Ind. 1980).
6. 578 S.W.2d 266 (Ky. Ct. App. 1979).
7. *Id.* at 269.
8. *In re Marriage of Graham,* 574 P.2d 75, 77 (Colo. 1978). This reasoning has been cited by a number of other courts. *See, e.g., Mahoney v. Mahoney, supra,* at 531; *In re Marriage of Lundberg, supra,* at 921; *Hubbard v. Hubbard, supra,* at 750; *Wisner v. Wisner, supra,* at 121.
9. 603 P.2d 747 (Okla. 1979).
10. *See, e.g., Leveck v. Leveck, supra; Frausto v. Frausto, supra.*
11. 318 N.W.2d 918 (Wis. 1982).
12. *Id.* at 922.
13. *DeLa Rosa v. DeLa Rosa, supra.*
14. 453 A.2d 527 (N.J. 1982). *Mahoney* dealt with an MBA degree rather than a medical license. Its reasoning, however, was applied in a sister case, *Lynn v. Lynn, supra,* dealing with a medical license.
15. 263 N.W.2d 885 (Iowa 1978). *Horstmann* dealt with a law degree, but the analysis should be equally applicable in cases involving medical degrees. *See supra,* note 14.
16. *Horstmann,* 263 N.W.2d at 891.
17. 631 P.2d 115 (Ariz. Ct. App. 1981).
18. 399 N.E.2d 371 (Ind. 1980). *McManama* dealt with a law degree but the analysis should be equally applicable in cases involving medical degrees. *See supra,* note 14.



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Hypertension — Low Cost Chemotherapy

ALBERT A. CARR, M.D. *Augusta**

ONCE THE DECISION has been made to initiate chemotherapy, the cost must be considered.[1] Compliance with therapy is essential, and this is affected by cost, availability of medical services, patient responsibilities, physician concern, patient education, and also adverse reactions.[2] The cost of chemotherapy, of course, varies with the drugs used and the severity of hypertension. The contribution of chemotherapy to overall cost was documented in a group of patients receiving medical care at this institution. It was 62% for those with severe high blood pressure (HBP) and 34% for those with mild HBP.[3]

Reserpine, hydralazine and hydrochlorothiazide prescribed in the generic forms are the cheapest chemotherapeutic agents available today. No other chemotherapy has been documented to be more effective in decreasing the incidence of mortality and morbidity of HBP. Patients with severe HBP, especially those with renal excretory failure, require other antihypertensive agents. However, if there is no contraindication to the use of these agents, patients with other than malignant HBP[4-6] and no renal excretory failure should receive either reserpine or hydrochlorothiazide or reserpine plus hydrochlorothiazide as the drugs of first choice. Hydralazine may be added, if needed. The combination of reserpine 0.2 mg daily, hydrochlorothiazide, and hydralazine has been documented to reduce BP effectively and to decrease the complications of HBP in patients with moderately severe and milder HBP.[7-9] In another study, reserpine with hydrochlorothiazide was equally effective as propranolol with hydrochlorothiazide.[10] Reserpine and hydrochlorothiazide were used effectively in the Hypertension Detection and Follow-up Cooperative Group Study.[11-14] Reserpine in doses of .05 to .25 mg daily, in combination with chlorthalidone has been documented to be very effective in lowering BP.[15]

Compared to propranolol, hydrochlorothiazide has been documented to be more effective in lowering HBP to levels less than 90 mm Hg.[16-17] Hydrochlorothiazide was much more effective in blacks than in whites.[24]

Reserpine has the reputation for causing more adverse reactions than other adrenergic-acting drugs.[18] However, the number of adverse reactions to reserpine observed in double-blind trials was not greater than the number observed in patients taking diuretics or propranolol.[10-17] There is more nasal stuffiness with reserpine.[10] The reported adverse effect of reserpine on myocardial norepinephrine content occurred with daily doses of 0.5 to 1.0 mg.[19] The Boston Drug Surveillance Program reported an increased incidence of breast cancer in association with

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Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Laurence O. Watkins, M.D., "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

reserpine.[20] However, another retrospective study did not confirm this association.[21] There is no good evidence to deny women the use of reserpine for fear of breast carcinoma.

Hydrochlorothiazide is generally well tolerated. In a double-blind study, it had to be discontinued because of adverse reactions only once, whereas seven patients on propranolol had to discontinue that drug because of side effects.[16-17]

Hypokalemia, potassium depletion, and ventricular premature beats have been reported in association with diuretic treatment.[22] However, no report yet has documented premature deaths due to diuretic-induced potassium depletion in hypertensive patients. In patients with acute myocardial infarctions, ventricular fibrillation is more frequent when serum potassium is less than 3.0 mEq/L.[23] Some authorities believe that mild hypokalemia causes no serious adverse reactions.[24] It was implied in the report of the Multiple Risk Factor Intervention Trial (MRFIT) that diuretics might have caused premature deaths in hypertensive men with pretreatment ECG abnormalities.[25] However, the number of deaths of patients taking a diuretic was not significantly higher than the number of deaths of patients not taking a diuretic.

There is now concern over long term effects of diuretics and beta blockers on lipids and other risk factors for atherosclerosis.[26-27] However, it should be realized that none of the prospective trials of chemotherapy for HBP has demonstrated a significant decrease in the incidence of myocardial infarction or atherosclerotic events. The benefits of therapy are reduced incidence of death and of hypertensive events.

To date, no clear evidence points to an advantage of any of the adrenergic-acting agents over reserpine. Also, there is no evidence to show that adrenergic-acting drugs (reserpine, clonidine, methyldopa, guanabenz, prazosin, and beta-blockers) when used as monotherapy are superior to diuretics. When renal function is normal, furosemide is not as effective as hydrochlorothiazide.[28] Whether or not a diuretic or an adrenergic-acting agent is used first depends on individual physician choice. The Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure recommended a stepped-care approach.[29] This was outlined because it would allow for the synergistic action of various agents and permit smaller doses of individual drugs. It was suggested that this would produce desired control of BP with a minimum of adverse side effects and patient inconvenience. This has not been documented to be true. However, if it is convenient for the physician, paraphysician personnel and patient, then such a method of treatment can be appropriate. There are obviously some patients for whom diuretics might be inappropriate, for example, those with hematocrits which are abnormally high or at the upper limit of normal, or angina or transient ischemic attacks. Patients with both angina and HBP would be ideal candidates for a beta-blocker. If rapid control of BP is required, then clonidine is an ideal agent.

The art of medicine requires that the treatment of patients with HBP should be individualized. The total patient, especially the patient's other medical problems and the patient's economic circumstances must be considered. For many people the cost of antihypertensive agents is significant. The low cost agents such as hydrochlorothiazide, reserpine and hydralazine can be a great help to those individuals and their use results in adequate control of the HBP.

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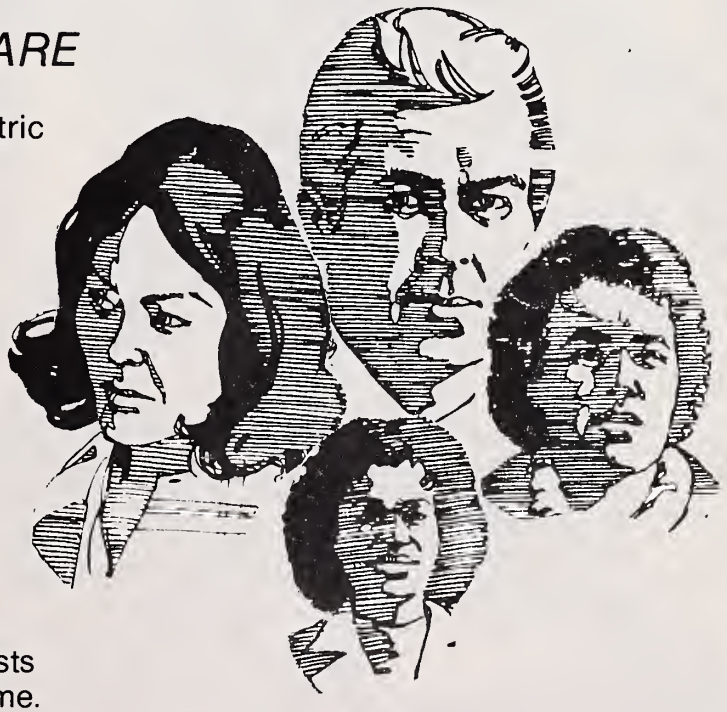
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president's letter



Have You Told Them Yet?

In the August issue of the *Journal,* you found a complete text of the AMA Council on Medical Services Report-D of the 1983 Annual Session regarding a proposed new method of physician reimbursement by third parties. If you have not already done so, please read and digest this comprehensive report. It is particularly timely in view of the pressures that are being brought to bear by a variety of third party payment mechanisms and methods upon our practices as physicians. Every component (state and territorial associations) society and all medical specialty organizations are being asked to bring their input to the AMA for a decision regarding AMA policy in this matter to be determined at the December meeting of the House of Delegates in Los Angeles. The report is quite comprehensive, and I think you will find it stimulating to review the material that is presented. Your directors and officers need to have the benefit of your feelings and advice in this important matter. Please do it now, because time is of the essence.



William W. Moore, Jr., M.D.

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PERSONALS

Third District

George M. Storey, M.D., has opened an orthopedic practice in Americus.

Fifth District

Atlanta physician, **A. Hamblin Letton, M.D.,** has been named to the Selection Committee to determine the winner of the Kuwait International Cancer Prize. There will be a meeting in Geneva, Switzerland in December to make this determination.

James C. Tanner, Jr., an Atlanta general surgeon, spoke at the Shrine Burn Hospital for Children in Cincinnati, Ohio, in July. His subjects related to the skin graft technique he developed in 1963. They were (1) Evaluation of Expanding Skin Grafts and (2) Effect of Collagen, Myofibroblast, and Contracture in Wound Healing. Dr. Tanner was also appointed a Visiting Professor of Surgery at the University of Cincinnati Shrine Burn Unit.

SOCIETIES

On June 4, 1983, the **Georgia Medical Society** sponsored a Sports Screening Program for all students participating in sports in both public and private schools throughout the county. There was no charge for the physicals given by volunteer physician members of the Society to the middle and high school students. Endurance tests were also given. The Society held an earlier screening program in January of this year.

The 11th Annual Athletic Injury Symposium, sponsored by the **Georgia Medical Society,** was held on July 28. Coaches in all sports, athletes, trainers, and physicians participated in this symposium. The purpose was to inform about and help prevent athletic injuries among public and private school students and little league participants. A total of 65 people attended the symposium which was organized by the Sports and Medicine Committee of the Society. Dr. Paul F. Jurgensen is chairman of that committee.

DEATHS

Harold Paul McDonald, Sr.

Harold Paul McDonald, Sr., M.D., Atlanta urologist, died July 17. Dr. McDonald was vice president of the McDonald Urology Clinic. He was a graduate of the Emory University School of Medicine. He formerly served as president of the Fulton County Medical Society, the Atlanta Urological Association, the Southeastern Section of the American Urological Association and the Georgia Urological Association. He was also president of the Georgia Board of Medical Examiners.

Dr. McDonald is survived by his wife, two sons, two sisters, and two brothers.

Highlights — MAG Executive Committee, June 1983,

Among the business considered at its June 3, 1983, meeting, the MAG Executive Committee took the following actions:

—Requested that the Impaired Physicians Committee (IPC) prepare a proposed policy statement which would reflect what constitutes an MAG Advocacy Impaired Physicians Program;

—Reiterated its desire that disciplinary action of the IPC written on MAG letterhead be approved by the MAG Executive Director or President;

—Appointed a Computer Advisory Committee to oversee activities of the MAG Information Systems;

—Agreed to meet with representatives of GTE Telenet Medical Information Network to discuss the possibility of MAG becoming a distributor of computerized medical information in Georgia.

Highlights — MAG Board of Directors, June 1983

At its June 4 meeting, the MAG Board of Directors approved plans for the implementation of all House of Delegates actions with specific recommendations to expedite action relating to:

1. Implementation of a major public relations campaign to improve the physician's image and promote the private practice of medicine;
2. Resolution 4 — Freestanding Medical Clinics;
3. Resolution 10 — Cost of Medical Care;
4. Resolutions 6 and 14 — Preferred Provider Organizations;
5. Resolution 17 — Usual, Customary, and Reasonable Fees;
6. Resolution 18 — Definition of Private Practice of Medicine; and
7. Consideration of the total panorama of today's practice of medicine.

The Board also approved mailing of a benefit package and programs offered to MAG members and gave final approval for printing and distribution of an HMO brochure developed by the Medical Practice and Public Relations Committees.

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Highlights — Executive Committee Meeting — July 17, 1983

Physician Recruitment

The Executive Committee agreed to the employment of a full-time, professional staff person to work in the area of physician recruitment. Eighteen of Georgia's Appalachian counties are presently designated as health manpower shortage areas. The funding will be provided by the Appalachian Regional Commission.

Free-standing Emergency Centers

The Executive Committee adopted several guidelines concerning the proposed rules and regulations for free-standing emergency care clinics. The Executive Committee agreed that:

1) A center should not be allowed to use the term "emergency" unless it is prepared to treat life and/or limb-threatening conditions;
2) Such a center should be open 24 hours a day, 7 days a week and be subject to stringent regulations; and
3) By implication, facilities offering immediate care should not be subject to regulation, though they should have to stop using the term "emergency."

MAG's guidelines will be submitted to the Georgia Department of Human Resources.

Legislative Seminar

The Executive Committee approved a 1983 Legislative Seminar to be held October 21-23 at the Amelia Island Plantation, Amelia Island, Florida. The October Executive Committee meeting will be held in conjunction with the Seminar.

Medicaid Recovery of Overpayments

Mr. Aaron J. Johnson, Commissioner of the Georgia Department of Human Resources, appeared before the Executive Committee to explain DHR's position concerning the overpayment of Medicaid funds to some 3,000 Georgia physicians. Mr. Johnson reported that his department would work cooperatively with those physicians receiving overpayments in recouping the monies. He explained the error was the fault of DHR, and in no way was any physician responsible for the overpayment. Mr. Johnson reported that a better explanation would be forthcoming and sent to individual physicians itemizing charges of overpayment. Dr. Delutha King, president of the Georgia Medical Association, also appeared before the Executive Committee to discuss that organization's concerns. The Executive Committee agreed that legal counsel for both groups should confer to discuss the possibility of legal relief to the situation.

Expansion of Ridgeview Institute

Ridgeview Institute requested the Executive Committee to support Ridgeview's request for a Certificate of Need (CON) to add a 34-bed unit to expand the inpatient treatment capability for impaired health professionals. The Executive Committee agreed to support Ridgeview's CON request.

Blue Cross/Blue Shield Participating Physicians Program

Charles Todd, MD, Chairman of the Board for the Atlanta Blues, presented to the Executive Committee their concept of a Participating Physicians Program which would require participating physicians to accept payment at the 90th percentile of UCR fees as determined by the Blues, as payment in full for services provided Blue Shield policyholders. Dr. Todd explained that this was an opportunity for the Blues and physicians to work together on a voluntary basis as far as cost of health care is concerned. It would assure physicians of equitable reimbursement for their efforts and services and protect the fee-for-service concept, freedom of choice for patients and physicians.

Ethan F. Staats, MD, President of the Metro Atlanta Foundation for Medical Care, also addressed the Executive Committee.

After discussion the Executive Committee accepted the Blues report as information.

MAG President Moore requested (1) that a summation of this report and comments be obtained from the tape of this meeting and that a synopsis of the points to be considered be derived therefrom in order that a formal action can be taken at the August Executive Committee meeting; and (2) apprise MAG membership by MAG *Newsletter* or an all-member mailing in those counties within the Atlanta Shield plan area, of the fact that a full discussion has been held and a decision will be made concerning this matter.

Georgia Nurses Association Request

The Executive Committee was requested to endorse the concept that all nurses in Georgia should have the opportunity to obtain baccalaureate degrees in nursing, with tuition reimbursement. The request came from the Georgia Nurses Association. The Executive Committee accepted the request as information and approved submission of this request to the MAG Committee on Nursing for its recommendations.

Selling the MAG Building

The Executive Committee agreed in principle to consider the possible sale of the MAG building to MAG Mutual Insurance Company, assuming a price can be agreed upon and the details of a contract worked out. A meeting was scheduled for July 26 to meet with appraisers to discuss setting a value on the building and to evaluate the future of the neighborhood in which the building is located. Specifics of the sale and contractual obligations are to be presented to the MAG Board of Directors at its September meeting.

MAG Mutual Insurance Company Update

Charles D. Hollis, Jr., MD, president of MAG Mutual, reported that MAG Mutual has currently 1,334 physicians insured; has written annual premiums in an amount of $3,800,000; has assets of approximately $8,000,000, and invested assets of $6,200,000. The report was accepted as information.

Harrison L. Rogers, Jr., Campaign

The Executive Committee heard a report of the plans that are being formulated for the campaign of Harrison L. Rogers, Jr., MD, as president-elect of the AMA. A letter and brochure will be distributed at the December AMA Interim Meeting. The MAG Board of Directors will be asked to contribute to the campaign at its September meeting.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from April through June, 1983.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Larry L. Akerman, Savannah
Olav H. Alvig, Cumming
José Luis Balbona, Atlanta
D. Louis Barrow, Atlanta*
Clorinda S. Bohler, Augusta
Malcolm G. Bowen, Conyers*
Andrea C. Bradford, Augusta*
Henry A. Brandt, Savannah
Jerome L. Bronikowski, Decatur*
Nyda W. Brown, Atlanta
Marcia V. Byrd, Marietta*
Richard E. Cherncky, Lawrenceville
Nicholas C. Chubb, Martinez
Mark G. Coan, Atlanta
Robert T. Connor, Rome
John B. Covell, Ellerslie*
J. Samuel Cruise, Smyrna
Alfonso T. Dampog, Snellville
William S. Davis, Rome
Jayaprakash Desai, Lawrenceville
Lawrence C. Dill, Tifton*
Charles W. Dodgen, Thomaston
William R. Dunn, Cumming
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JOURNAL
of the medical association of georgia
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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

The Georgia Medical Political Action Committee (GaMPAC) can continue to influence the outcome of elections in Georgia only through the financial support of MAG members. The enclosed editorial by Dr. Beverly B. Sanders, Jr., and the articles by Lieutenant Governor Zell Miller and U.S. Congressman Newt Gingrich discuss the impact of PACs on Georgia politics. Contribute to GaMPAC when you pay your annual MAG dues and allow the voice of medicine to make a difference in Georgia elections.

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MEDICAL MEETING CALENDAR

OCTOBER

12-16—*Hilton Head, SC:* **Southern Clinical Congress of Obstetrics and Gynecology.** Contact Stan Martin, SCC of OBGYN, P.O. Box 2121, Augusta 30903-2121. PH:404/722-1381.

12-16—*Wildwood:* **Something Better: Ninth Annual Seminar in Physiology and Medicine.** Contact Marjorie Baldwin, MD, P.O. Box 109, Wildwood, GA 30757. PH:404/890-1493, x330.

13-16—*Sea Island:* **Georgia Orthopaedic Society Annual Meeting.** Category 1 credit. Contact William Collins MD, Secy.-Treas., 993-C Johnson Ferry Rd., Atlanta 30342. PH:404/255-4582.

14-15—*Columbus:* **MAG Risk Management Seminar.** Cosponsored by the Muscogee County Medical Society. Category 1 credit. Contact Barbara Dent, Exec. Secy., Muscogee County Medical Society, 232 Doctors Building, Columbus 31901. PH:404/322-1254.

14-16—*Augusta:* **Medical Fair and Pre-Practice Seminar for Residents.** Contact Gould Hagler, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in GA).

15—*Atlanta:* **Birth Defects: A Challenge to Families and Health Care Professionals.** Contact Stephen Daniel, Ph.D., Dir. of CME, Morehouse Sch. of Med., 720 Westview Dr., SE, Atlanta 30310. PH: 404/752-1351.

16-21—*Atlanta:* **American College of Surgeons Clinical Congress.** Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH:312/664-4050.

19-22—*Hilton Head, SC:* **Fifth Annual Hilton Head Symposium on the Clinical Management of Diabetes and Endocrine Disorders.** AMA Category 1 and AAFP prescribed credits. Contact Edwin Bransome, Jr., MD, Dept. of Med., MCG, Augusta 30912. PH:404/828-3445.

20-23—*Callaway Gardens:* **Rehabilitation of the Coronary Patient.** Cosponsored by Amer. Coll. of Cardiology, Emory Univ. Sch. of Med., and Ga. Affil., Amer. Heart Assn. Category 1 credit. Contact Registration Secretary, Extramural Program Dept., ACC, 9111 Old Georgetown Rd., Bethesda, MD 20814. PH:301/897-5400, x226.

21—*Atlanta:* **Immunohemotherapy: Recent Advances in Intravenous IgG Therapy.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

21-23—*Amelia Island, FL:* **MAG Legislative Seminar.** Contact Hollie Ross, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in GA).

22-27—*Atlanta:* **American College of Emergency Physicians.** Contact ACEP, P. O. Box 61911, Dallas, TX 75261. PH:214/255-3553.

25-27—*Atlanta:* **EMG Feedback Application in Rehabilitation.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26—*Atlanta:* **5th Annual Joseph S. Skobba Symposium on Milieu Treatment.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

26-28—*Atlanta:* **Neuroradiology Update—1983.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

29 — *Atlanta:* **MAG Conference on Medical and Legal Issues.** Contact Wayne Oliver, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535.

NOVEMBER

6-9—*Unicoi:* **20th Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

7-11—*Augusta:* **Review Course in Obstetrics and Gynecology.** Sponsored by the Medical College of Georgia School of Medicine. Category 1 credit. Contact Div. of Continuing Education, MCG, Augusta 30912. PH:404/828-3967.

9-13—*Atlanta:* **Georgia Academy of Family Physicians Annual Scientific Assembly.** Category 1 and AAFP prescribed credit. Contact GAFP, 11 Corporate Square, Ste. 205, Atlanta 30329. PH:404/321-7445.

10-11—*Atlanta:* **Controlling Utilization: The First Step in Coping with Prospective Payment.** Category 1 credit. Contact InterQual Inc., 1165 N. Clark St., Ste. 606, Chicago, IL 60610. PH:800/621-6109.

11—*Atlanta:* **Symposium on Myasthenia Gravis.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

11-12—*Atlanta:* **A Basic Course in Phacoemulsification and Extracapsular Cataract Extraction with Posterior Chamber Lens Implantation.** Category 1 credit. Contact Mrs. Ginger Lineberger, Hallum-Arnold Eye Found., Inc., Ste. 206, 3280 Howell Mill Rd., NW, Atlanta 30327. PH:404/351-2713.

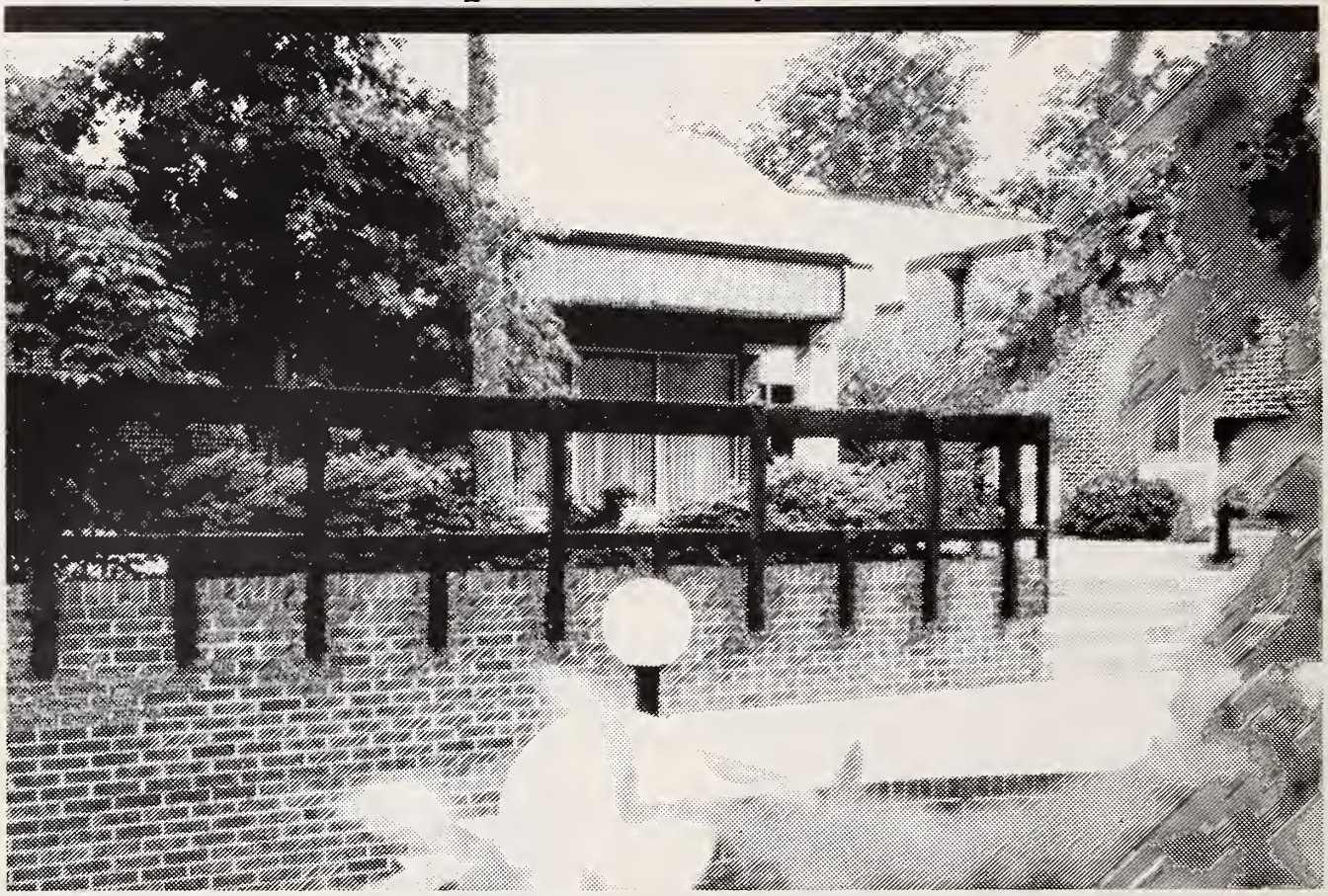
17-20—*Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester C. Lane, Exec. Secy., 69 Butler St., SE, Atlanta 30303. PH:404/588-3540.

18-20—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree Street, NE, Atlanta 30309. PH:404/876-7535 or 800-282-0224 (toll free in GA).

20—*Atlanta:* **4th Symposium on Health Care in Correctional Institutions.** Contact Dorothy Parker, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in GA).

30-Dec. 4—*Atlanta:* **Eighth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

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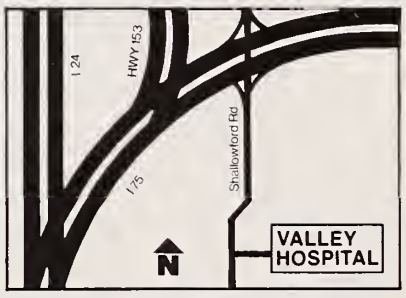


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mean	68%	98%	96%	95%
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mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

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US Patent 3,657,267
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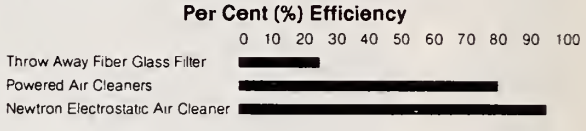
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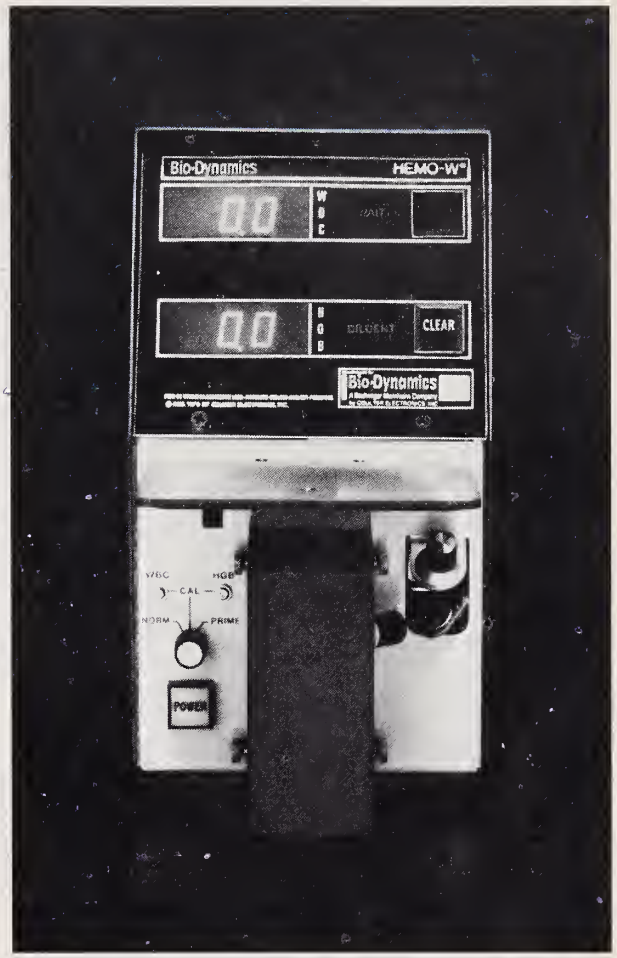
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In vitro studies demonstrate

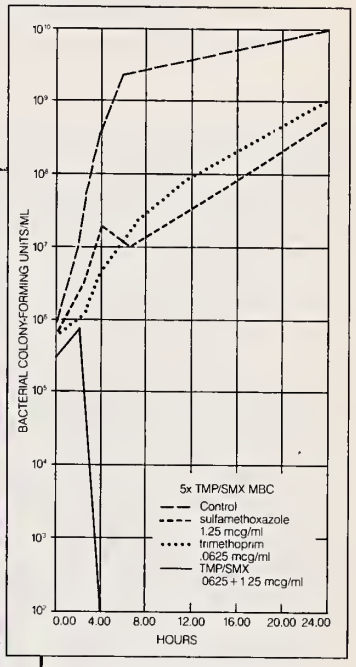
Bactericidal activity with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus sp.*	*Enterobacter sp.*	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofur-antoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI* *



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro*.[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J *et al: Rev Infect Dis 4*:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther 3*:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother 6*:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J 1*:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol 111*:670-672, May 1974. 9. Iravani A *et al: Antimicrob Agents Chemother 19*:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol 125*:825-827, Jun 1981. 11. Rous SN: *J Urol 125*:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS
(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: *Not recommended for infants less than two months of age.*
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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JOURNAL
of the medical association of
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In Praise of PACs

U.S. CONGRESSMAN NEWT GINGRICH, *Atlanta**



U.S. Congressman Newt Gingrich

WE ARE IN A REVOLUTION in American politics. That revolution is being greatly undercovered by the press because the press is focusing on the wrong things.

With the campaign "reform" laws of the mid-seventies came profound changes in American politics. Wealthy people have been restricted in their direct contributions. There has been an explosive emergence of a whole new zone of activity, symbolized by the prevalence of political action committees (PACs). These PACs have brought a whole new generation of people into the world of campaign contributions and they are tying political behavior in campaigns to political behavior in governing more tightly than has been the case in the last 30 years.

Political action committees are bringing informed interest groups out in the open, so that we can begin to see a real relationship among the way people behave in elections, the way people behave in contributions, and the way congressmen vote. PACs can move us away from what the Founding Fathers feared our democracy would drift toward: an *atomistic* society.

PACs can move us away from what the Founding Fathers feared our democracy would drift toward: an atomistic society.

In the atomistic model of a free society, there is a general, vague "common good" which is normally given to us by a Ralph Nader or a John Garner. It is communicated through television and then we, as 225 million individual atoms working in a plebiscitary system, say, "Yes. Do this. No, don't do that." That is precisely the Aristotelian vision of mob politics, which the Founding Fathers thought might be the end of this society.

The only workable alternative to that system is a mediating institution society, in which a great number of small sub-groups, acting separately, protect both the individual and the government. Mediating

* Mr. Gingrich is the Republican Representative from the Sixth Congressional District of Georgia.

institutions prevent the government from crushing any individual and prevent individuals from forming into a plebiscite which crushes the government and turns it into a tyranny.

Traditionally, we have had mediating institutions, such as county courthouses and big-city machines. They are in decay. But a new mediating institution is emerging: *the political action committee*. It is not geographic but instead based on common interest. It is tied together by newsletters, mailgrams, and annual conventions. It is at least as accountable as was the big-city machine.

In order to attract contributions, the PAC has to in some way reflect the interest of the people who give to it. Because the PAC is organized, it allows the individual voter to know that somebody is watching out for his interests — and is probably doing a better job of it than his congressman is. That congressman, after all, has to represent 10,000 differing interests — or as many as will be found among his 500,000 constituents.

Mediating institutions within a society protect both the individual and the government.

So the PAC is our new watchdog, legitimately looking out for the interests of its contributors. This pattern is as old as American politics. It's why Jefferson's farmers were opposed to Hamilton's shipowners and merchants. People who were elected by Jefferson's farmers tended to vote against the interests of Hamilton's shipowners and merchants. The idea behind PACs is nothing new. We are merely talking about a different structure, reflecting old patterns, that more openly relates campaign contributions to politicians' behavior in office.

People who say that PACs are bad are, in effect, saying that voters ought to elect people on one set of campaign promises who should then be allowed to do anything they want to in between campaigns. That's the bottom line: The campaign promises, and the contributions they encourage, should have no relationship to the actions of the people that the money and the promises elevate to Congress.

But that is rampant nonsense. To say that "special interests govern the Congress" assumes special interests are a monolith. I know from experience that they are not. For example, I found myself siding with Georgia Power and the rural electric co-ops by voting for coal slurry pipeline legislation — which was a vote against the railroad. A few weeks later, I opposed the Eckhardt amendment to the rail deregulation bill, which was a vote for the railroads and against the interests of Georgia Power and the rural electric co-ops.

Which PAC is now supposed to own me as a congressman? Am I under the sway of the PACs who backed the pipeline or the PACs who favor the railroads? In each vote, I was on the side I thought correct for America's technologic expansion. That was the only constant, and to talk of all pervasive "special interests" is to assume constancy where there is little: the PACs will line up differently on different issues.

PACs are tying political behavior in campaigns to political behavior in governing more tightly than has been the case in the last 30 years.

If Common Cause really wanted more people involved in politics, that organization would favor increasing the number of PACs as rapidly as possible — whether the new PACs reflected quality-of-life interest groups like the Sierra Club, age-based interest groups like the senior citizens associations, geographic interest groups like the neighborhood and regional organizations, or newly-emerging economic interest groups.

To those who fear money in politics, let me say that we need more, not less, money in politics. PACs are not disgracing American politics. The disgrace, to cite a specific case, comes when Jay Rockefeller spends $31 per vote out of his own pocket to buy a governorship. And the disgrace, to cite a general reality, is the overwhelming power of incumbent congressmen to get re-elected. There's something fundamentally wrong when, even in a bad year for incumbents, 93 percent of House members seeking re-election get re-elected.

Our real purpose should not be to view politics as a gladiatorial contest between two ambitious people. Politics should be the process by which the country talks to itself about its future, a politics powered by a public that is reasonably informed about the candidates on the levels at which it decides to vote. Measured against that standard, we have a pitifully discouraging system because, in part, we are starving it to death.

The PAC is our new watchdog, legitimately looking out for the interests of its contributors.

Compare the amount of money we spend on politics with what Coca-Cola or General Motors spends on advertising. We spend more of our national income telling ourselves what to drink and what to drive then we do on deciding our political destiny. Politics is, after all, the zone in which we discuss the management of a free society. And there is a tendency to confuse what is spent on government with what

is spent on politics. But money spent on government goes for bureaucracy, while money spent on politics determines what kind of political management this society will have. Any corporation which spent, as a percentage of its total economic activity, the same portion on management as our society does on politics would go bankrupt.

The challenge for the 80s is to steadily increase the relationship between a person's vote and the behavior of the government.

A free society needs a free competitive system. I have far more faith in private dollars freely given by free citizens to the PACs that will be their watchdogs than I do in any kind of public financing of congressional campaigns. If the congressman whom you distrust because he will be "corrupted" by PACs would be in charge of a public financing system, why would you trust that public financing system?

The challenge for the 80s is to steadily increase the relationship between a person's vote and the behavior of the government. PACs are a strong and healthy step in that direction. We need more, not fewer.

The American Medical Association and the Medical Association of Georgia should be commended for realizing years ago the importance and the place for American Political Action Committee (AMPAC) and Georgia Medical Political Action Committee (GaMPAC). These two independent organizations are leaders in the state and the country as PACS that have credibility with the congressmen and local legislators.

It is through your PAC that you help elect representatives to the U.S. Congress and the Georgia legislature. Their votes could make the difference regarding passage of legislation affecting the destiny of you as a taxpayer and the future of the quality of medical care.

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When we refuse to become involved in politics, we are by that very action abandoning democracy to the very governmental bureaucracy we profess to distrust.

Politics of the Possible

LIEUTENANT GOVERNOR ZELL MILLER, *Atlanta*

THE ALL-PERVASIVE GROWTH of government in recent decades, combined with episodes like Watergate and the Vietnam War, has led many people to feel skeptical about both the motives and competence of government. "I'm from the government, and I'm here to help you" has about as much credibility as "The check is in the mail." Many see politics as a dirty game played by unscrupulous players, and their response has been to drop out, to avoid becoming involved.

The truth is that politics, like anything else, may get dirty at times, and that there are some unscrupulous politicians, just as there are quacks and unscrupulous physicians to be found in the medical profession. It is true of any profession one may choose to examine.

But politics is more than just a game. Politics decides whether a mother whose husband has abandoned her will have food for her children, whether a child will learn to read, whether our elderly will have proper care, whether it will be safe to walk the streets.

The decision-making power in a democracy is vested in its citizens, and politics is the process by which those citizens, whether it be on the local, state, or national level, decide the direction they want to take on matters of mutual concern.

A choice on their part to ignore politics is an abdication of the power that is vested in them, a denial of the fundamental premise upon which democracy is based. When we refuse to become involved in politics, we are by that very action abandoning democracy to the very governmental bureaucracy we profess to distrust.

Government bureaucracy by itself has an insatiable appetite. Left to its own devices, it becomes anxious to please everyone, and the more caught up it becomes in that goal, the more difficulty it has accomplishing it. It conscripts more and more of the public wealth for political purposes, with the result of a mushrooming growth of law, of executive discretion as a result of that law, of exhausted legislators, and of a short-tempered public.



Lieutenant Governor Zell Miller

Only through abdication of their responsibility by the citizenry did this snowballing process get started;

only when citizens become concerned and involved in helping government set its priorities will it reverse. The comic-strip character Pogo, who lives in Okefenokee Swamp, made famous the saying, "We have met the enemy and the enemy is us." We as a people have created the political disillusionments and problems that plague us.

No matter what level of government we talk about, democracy calls for citizens to evaluate realistically what government is able to do and what it should do. We need to master the "politics of the possible."

In a democracy, being a citizen means being a politician.

The "politics of the possible" means weighing and censuring the many demands and requests laid before government. The "politics of the possible" means understanding together what our resources are and coming to a consensus about the tax burden we are willing to bear in exchange for the services it will realistically provide.

Part of the disillusionment about government is a result of unrealistic expectations in this area. People have come to expect that government will educate their children, transport them to their jobs, project their neighborhoods, provide their health care, collect their garbage, preserve their environment, rebuild their cities, provide them with recreational facilities, protect them from fraud, create jobs for them, maintain a stable business climate, and provide life-support systems for those who are unable to sustain themselves. But nobody wants to pay the kind of taxes that are required for all those services.

The role of government in a democracy is not to be all things to all people, but to provide citizens with the tools they need to make their own decisions and better their own lives and those of their neighbors.

Government should be a foundation for the work of people who care enough to cooperate with each other in finding solutions to their mutual problems. Government needs to be a skeleton that is fleshed out by its citizens, an enabling framework upon which its people build.

Back in ancient Greece, a man named Thucydides delivered the equivalent of Lincoln's Gettysburg Address on the occasion of a memorial service for those Athenians who had died in the Peloponnesian War. In it he quoted from Pericles the following:

"An Athenian citizen does not neglect the state because he takes care of his own household. . . . We alone regard a man who takes no interest in public affairs not as a harmless, but as a useless character . . . and if few of us are originators, we are all sound judges of a policy."

In a democracy, being a citizen means being a politician. You, as a Georgia physician and an active member of the Medical Association of Georgia, live in a democracy, practice medicine in a democracy, and by the nature of your profession are a politician. As a political physician, there are certain things you must do in order to preserve the democracy you live in today and to preserve the quality of medicine you practice and the quality of health care for our citizens — your patients.

Without your activity and your voice, the effectiveness and quality of our democracy is diminished. With your voice, it is enhanced and anything is possible. In the political arena, the results of politics is most definitely possible.

Part of the disillusionment about government is a result of unrealistic expectations. . . .

Your voice can be heard in Georgia politics through your political action committee, GaMPAC. I know first hand that this committee plays an important role in the election process. Without this arm of organized medicine, you would not have a statewide voice in selecting those candidates that decide your fate as taxpayers and as physicians.

With more than 7,000 licensed medical doctors in Georgia, you can and should have the largest PAC in Georgia, and thus influence the outcome of more legislative elections. Your destiny rests in your hands and your PAC and your membership. In GaMPAC, the outcome of politics is possible.



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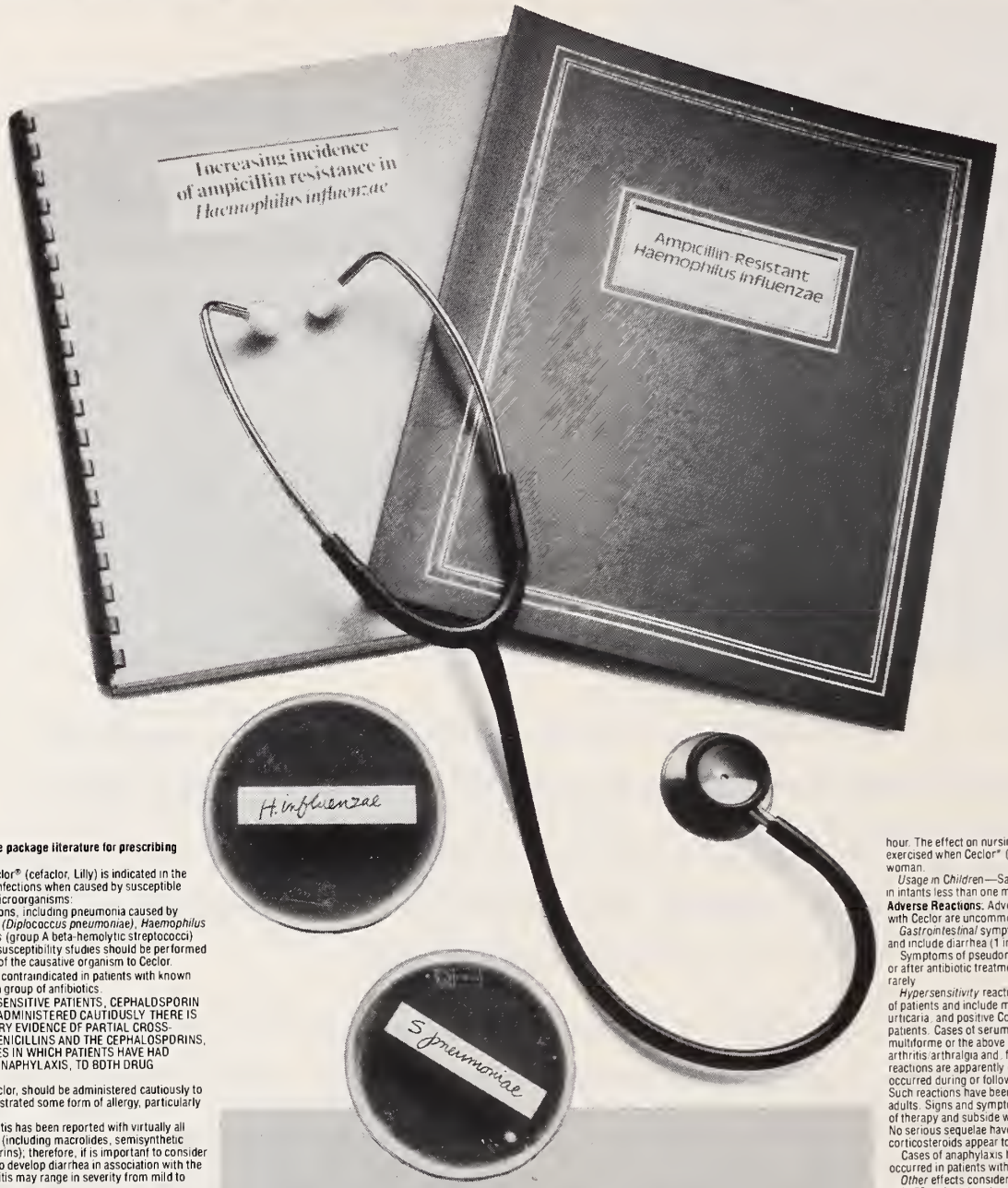
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy) II:880. Washington, D.C., American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York, John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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MAG Scientific Assembly 1983

PRELIMINARY PROGRAM

REGISTRATION INFORMATION

Your registration form for the 1983 MAG Scientific Assembly may be found in this issue of the *Journal*. If you need another form, call the MAG office in Atlanta (876-7535 or toll free in Georgia: 800/282-0224). We will gladly mail you one. Early registration is advised. General Registration desks will also be open during the Scientific Assembly.

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Fee for other health professionals is $20

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If you wish hotel accommodations, please complete and detach the bottom portion of the registration form and mail it directly to the Colony Square Hotel by October 27, 1983. As stated on the hotel card, Thursday reservations must be guaranteed. Should you not arrive on this date or call in the cancellation before 6 p.m., you will be billed for both the room and tax. Friday and Saturday reservations will be held until 6 p.m. unless guaranteed or covered by deposit.

ALLERGY

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

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Fellow, Allergy and Immunology
Medical College of Georgia School of Medicine
Augusta, Georgia

Kenneth Peirce, M.D.
President, Allergy and Immunology Society of Georgia
Columbus, Georgia

FRIDAY, NOVEMBER 18

PRESIDING:
Kenneth Peirce, M.D.

12:00-1:20	**LUNCHEON** Sponsored by Muro Pharmaceuticals
1:30-2:30	**PERSISTENT SMALL AIRWAYS DISEASE** Arlene Hutchison, M.D.
2:30-2:45	**Questions and Discussion**
2:45-3:15	**CASE PRESENTATION** Larry Smith, M.D.
3:15-3:30	**Break**
3:30-4:00	**PROGRESS IN ALLERGY** Kenneth Peirce, M.D.
4:00-5:00	**Business Meeting** Allergy and Immunology Society of Georgia
5:00-6:00	**Reception** Sponsored by W. E. Hauck Pharmaceuticals

MANAGING THE ARTHRITIC PATIENT

A collaborative effort of the Arthritis Foundation and Syntex Laboratories in cooperation with the American Academy of Family Physicians

SPONSORED BY GEORGIA RHEUMATISM SOCIETY

PROGRAM CHAIRMAN:
Sanford S. Hartman, M.D., Atlanta

FACULTY

Charles M. Plotz, M.D., Med. Sc. D.
Professar of Medicine
SUNY Dawnstate Medical Center
Braoklyn, NY

M. Thomas Stillman, M.D., F.A.C.P.
Director, Division of Rheumatalogy
Hennepin County Medical Center
Assistant Professar of Medicine
University af Minnesota Medical School
Minneapolis, Minn.

FRIDAY, NOVEMBER 18

9:00- 9:50 **RHEUMATOID ARTHRITIS**
CASE #1: ARTHRITIS OF THE HANDS IN A YOUNG WOMAN
Charles M. Plotz, M.D., Med. Sc. D.

9:50-10:35 **OSTEOARTHRITIS**
CASE #2: CHRONIC KNEE PAIN IN A 46-YEAR-OLD MAN
M. Thamas Stillman, M.D.

10:35-10:45 **Break**

10:45-11:30 **HYPERURICEMIA AND GOUT**
CASE #3: ACUTE ARTHRITIS OF THE KNEE IN A 37-YEAR-OLD MAN
Charles M. Plotz, M.D., Med. Sc. Ed.

11:30-12:15 **CASE #4: SOFT-TISSUE RHEUMATISM (Four Examples)**
(a) CHRONIC SHOULDER AND HIP PAIN IN A 70-YEAR-OLD WOMAN
(b) CHRONIC SHOULDER AND BACK PAIN IN A 45-YEAR-OLD MAN
(c) SHOULDER PAIN IN A 42-YEAR-OLD MAN
(d) PAIN IN THE RIGHT HAND IN A 35-YEAR-OLD WOMAN
M. Thamas Stillman, M.D.

12:15- 1:00 **ANKYLOSING SPONDYLITIS**
CASE #5: LOW BACK PAIN IN A YOUNG MAN

CHEST DISEASE

(Please Refer to TOPICS IN CRITICAL CARE)

TOPICS IN CRITICAL CARE

GEORGIA THORACIC SOCIETY
GEORGIA GASTROENTEROLOGIC SOCIETY
GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS
GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

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Carl Oettinger, M.D.
Assistant Professor of Medicine (Nephrology)
Emory University School of Medicine
Atlanta, Georgia

FRIDAY, NOVEMBER 18

GENERAL TOPICS IN CRITICAL CARE

8:30- 9:30 **HEMODYNAMIC MONITORING**
Roger Bone, M.D.

9:30-10:00 **SHOCK**
Rager Bone, M.D.

10:00-10:15 **Coffee Break**

10:15-11:15 **NOSOCOMIAL RESPIRATORY INFECTION**
Waldemar Jahansan, M.D.

11:15-12:00 **ACUTE RENAL FAILURE**
Corl Oettinger, M.D.

12:00- 1:30 **Lunch**

1:30- 2:15 **MASSIVE GI BLEEDING**
H. Worth Boyce, M.D.

2:15- 3:15 **NUTRITION IN THE CRITICALLY ILL (HYPERALIMENTATION)**
Jomes L. Mullen, M.D.

3:15- 3:30 **Coffee Break**

3:30- 4:00 **BLOOD SUBSTITUTES**
Stan Mogelnicki, M.D.

4:00- 5:00 **CASE PRESENTATION**
Ponel & Audience Discussion

5:00- 5:50 **GTS & GA. CHAPTER ACCP ANNUAL BUSINESS MEETING**

SATURDAY, NOVEMBER 19

PULMONARY TOPICS IN CRITICAL CARE
GEORGIA THORACIC SOCIETY

9:00-10:00 **ACUTE RESPIRATORY FAILURE**
Roger Bone, M.D.

10:00-10:30 **NOSOCOMIAL INFECTION IN ACUTE RESPIRATORY FAILURE**
Woldemor Johonson, M.D.

10:30-11:15 **THE RESPIRATORY MUSCLES — A GENERAL INTRODUCTION**
Eric Honig, M.D.

11:15-11:30 **Coffee Break**

11:30-12:30 **MUSCLES, FATIGUE AND WEANING FROM VENTILATORY SUPPORT**
Eric Honig, M.D.

12:30-12:50 **NUTRITIONAL SUPPORT IN RESPIRATORY FAILURE**
Gilbert Grossman, M.D.

12:50- 1:30 **Panel Discussion — Case Presentation**
Drs. Bone, Johanson, Honig & Grossmon

This progrom hos been partially funded through contributions from AEROX, Respiratory Home Care Services, Ciba-Geigy, Stansell's Oxygen Service, Glasrock Medicol Services, and Trovacare Respiratory Services. Dr. Johanson's visit is supported by Boeringer-Ingleheim Phormaceuticol Co. Dr. Bones' visit is supported by the Upjohn Co.

EMERGENCY MEDICINE

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Clinical Reseorch Investigator
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Clinical Assistant Professor of Dermatology
Emory University School of Medicine
Atlonta, Georgia

Foad Nahai, M.D.
Associate Professor of Plastic Surgery
Emory University School of Medicine
Crawford Long Hospitol
Atlanto, Georgia

SATURDAY, NOVEMBER 19

1:00-2:00 **UPDATE ON EMERGENCY DEPARTMENT MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES**
Stephen Kraus, M.D.

2:00-2:45 **HAND INJURIES IN THE EMERGENCY DEPARTMENT**
Foad Nohoi, M.D.

2:45-3:00 **Break**

3:00-4:30 **LAB DEMONSTRATION: TECHNIQUES OF PLASTIC WOUND MANAGEMENT IN THE EMERGENCY DEPARTMENT**
Food Nohoi, M.D.

GASTROENTEROLOGY

(Please refer to TOPICS IN CRITICAL CARE)

NEUROLOGY

GEORGIA NEUROLOGICAL SOCIETY

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Augusta, Georgia

Don King, M.D.
Medical College of Georgia School of Medicine
Augusta, Georgia

Saturday, November 19

9:00-12:00 **EPILEPTIC SEIZURES**

12:00- 1:00 **LUNCHEON**

1:00- 3:00 **EPILEPTIC SEIZURES**

Dr. Smith's visit is supported by Geigy Phormoceuticals.

NEUROSURGERY

GEORGIA NEUROSURGICAL SOCIETY

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Augusta, Georgio

Suzie Tindall, M.D.
Emory University School of Medicine
Atlonto, Georgio

SATURDAY, NOVEMBER 19

8:30-12:30 CRITICAL CARE OF NEUROSURGICAL PATIENTS

OPHTHALMOLOGY

GEORGIA SOCIETY OF OPHTHALMOLOGY

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Director of the Gloucomo Service
Massochusetts Eye and Ear Infirmary
Boston, Mossochusetts

SATURDAY, NOVEMBER 19

9:00-5:00 POTENTIAL USE OF YAG LASER IN GLAUCOMA
Dovid L. Epstein, M.D.
LASER IRIDECTOMY TECHNIQUES: FOLLOW UP AND COMPLICATIONS
Dovid L. Epstein, M.D.
PAPERS BY GSO MEMBERS

OTOLARYNGOLOGY/HEAD AND NECK SURGERY

GEORGIA SOCIETY OF OTOLARYNGOLOGY/ HEAD AND NECK SURGERY
GREATER ATLANTA SOCIETY OF OTOLARYNGOLOGY/ HEAD AND NECK SURGERY

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Augusta, Georgio

William E. Silver, M.D.
Otoloryngologist/Heod ond Neck Surgeon
Atlonto, Georgio

FRIDAY, NOVEMBER 18

9:00- 9:30 AIRWAY PROBLEMS IN CHILDREN
Robin Cotton, M.D.

9:30- 9:45 Discussion

9:45-10:15 LARYNGOTRACHEAL TRAUMA
Edword Porubsky, M.D.

10:15-10:30 Discussion

10:30-10:45 Coffee Break

10:45-11:15 CSF OTORRHEA & RHINORRHEA FOLLOWING HEAD TRAUMA
Newton Coker, M.D.

11:15-11:30 Discussion

11:30-12:00 PULMONARY FUNCTION STUDIES FOR EVALUATION OF THE PREOPERATIVE AND POSTOPERATIVE HEAD AND NECK SURGICAL PATIENT
Gory Lohous, M.D.

12:00-12:30 DELAYED TREATMENT OF TRAUMATIC NASAL INJURIES
Williom E. Silver, M.D.

12:30-12:45 Discussion

PATHOLOGY

GEORGIA ASSOCIATION OF PATHOLOGISTS
ATLANTA SOCIETY OF PATHOLOGISTS

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Jerry D. Porter, M.D., Atlonto

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Nashville, Tennessee

Edwin P. Ewing, Jr., M.D.
Chief, Ultrastructural Pathology Section
Host Factors Division
Centers for Disease Control
Atlanta, Georgia

SATURDAY, NOVEMBER 19

GEORGIA ASSOCIATION OF PATHOLOGISTS

9:00-12:00 PATHOLOGY OF THE ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
Russell K. Brynes, M.D.
Edwin P. Ewing, Jr., M.D.

SUNDAY, NOVEMBER 20

ATLANTA SOCIETY OF PATHOLOGISTS ANNUAL SLIDE SEMINAR

9:00-1:00 PATHOLOGY OF NEOPLASTIC LYMPHOPROLIFERATIVE DISORDERS
Robert D. Collins, M.D.

General cases for discussion have been submitted by members of the Atlanta Society of Pathologists and by Dr. Collins. Approximately 15 cases dealing with a wide spectrum of lymphoproliferative states have been prepared into a microscopic slide study set. Limited sets are available for $45.00, and requests should be mailed to: Jerry D. Porter, M.D., Atlanta Society of Pathologists, Department of Pathology, Saint Joseph's Hospital, 5665 Peachtree-Dunwoody Road, N.E., Atlanta, Georgia 30342. Make checks payable to: Atlanta Society of Pathologists.

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Atlanta, Georgia

Barry L. Warshaw, M.D.
Department of Pediatrics
Emory University School of Medicine
Atlanta, Georgia

FRIDAY, NOVEMBER 18

PRESIDING:
W. Dean Wilcox, M.D.

2:00-3:00 THE BASICS OF ADOLESCENT MEDICINE OR HOW TO SUCCESSFULLY TREAT TEENAGERS
Alan J. Sievert, M.D.

3:00-4:00 COLLAGEN VASCULAR DISEASE UPDATE
Donna L. Gibbas, M.D.

4:00-5:00 INCREASED INTRACRANIAL PRESSURE
Peter A. Ahmann, M.D.

SATURDAY, NOVEMBER 19

PRESIDING:
George W. Brumley, M.D.

8:30- 9:30 HYPERTENSION: EVALUATION AND MANAGEMENT
Leonard C. Hymes, M.D.

9:30-10:30 RENAL TRANSPLANT — CURRENT STATUS
Barry L. Warshaw, M.D.

10:30-10:45 Break

10:45-12:00 REACTIVE AIRWAY DISEASE
Thomas F. Smith, M.D.

12:00- 1:00 VIRAL MYOCARDITIS
Harry L. Keyserling, M.D.

PLASTIC SURGERY

GEORGIA SOCIETY OF PLASTIC SURGEONS

PROGRAM CHAIRMAN:
Robert E. Zaworski, M.D., Atlanta

GUEST SPEAKER:
Stephen J. Mathes, M.D.
Associate Professor of Surgery
Division of Plastic Surgery
University of California
San Francisco, California

SATURDAY, NOVEMBER 19

PRESIDING:
Maurice J. Jurkiewicz, M.D.
Chief, Division of Plastic Surgery
Emory University School of Medicine
Atlanta, Georgia

PLASTIC SURGERY — Continued

9:00-10:00 **COVERAGE OF THE INFECTED WOUND**
Stephen J. Mathes, M.D.

10:00-10:30 **Break**

10:30-11:30 **CURRENT CONCEPTS IN HEAD AND NECK RECONSTRUCTION**
Stephen J. Mathes, M.D.

PSYCHIATRY

GEORGIA PSYCHIATRIC ASSOCIATION

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Chief of Psychiary
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Medical College of Georgia Schoal af Medicine
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Veterans Administratian Medical Center
Augusta, Geargia

Alan Stoudemier, M.D.
Assistant Prafessar af Psychiatry
Emory University School of Medicine
Atlanta, Georgia

SATURDAY, NOVEMBER 19

9:00- 9:45 **ADVANCES IN ANTIDEPRESSANT MEDICATION**
Richard L. Borison, M.D.

9:45-10:30 **TREATMENT OF PAIN SYNDROMES**
Jeffrey L. Houpt, M.D.

10:30-10:45 **Break**

10:45-11:30 **BIOLOGICAL AND TREATMENT ADVANCES IN ANXIETY**
Philip T. Ninan, M.D.

11:30-12:15 **ALCOHOLISM**
E. Mansell Pattison, M.D.

12:15- 2:00 **Lunch**

2:00- 2:45 **THE INTERFACE OF MEDICINE AND PSYCHIATRY IN THE EIGHTIES**
Caral Ann Phillips, M.D.

2:45- 3:30 **MANAGEMENT OF THE SOMATIC PATIENT**
Alan Staudemier, M.D.

3:30- 3:45 **Break**

3:45- 4:30 **GRIEVING: BLOCKS AND RESOLUTION**
Richard W. Baggé, M.D.

RHEUMATISM

(Please refer to MANAGING THE ARTHRITIC PATIENT on Friday, November 18)

SURGERY

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

(Please refer to TOPICS IN CRITICAL CARE for program on Friday, November 18)

PROGRAM CHAIRMAN:
Eugene D. Davidson, M.D., Atlanta

VISITING FACULTY:
James L. Mullen, M.D.
Assaciate Prafessar af Surgery
University af Pennsylvania
Philadelphia, Pennsylvania

SATURDAY, NOVEMBER 19

PRESIDING:
Arlie Mansberger, M.D.
Department af Surgery
Medial College af Georgia Schaal af Medicine
Augusta, Georgia

8:30- 9:45 **RESIDENT COMPETITION**

8:30 **THE INCIDENCE OF GLIOBLASTOMA MULTIFORME IN GEORGIA**
Roger McLendon, M.D.
Medical Center of Central Georgia
Macon, Geargia

8:40 **Discussion**

8:45 **BLUNT AND PENETRATING TRAUMA DURING PREGNANCY**
M. Rick Timms, M.D., Carl R. Boyd, M.D., Robert D. Gongaware, M.D.
Memorial Medical Center
Savannah, Georgia

8:55 **Discussion**

9:00 **GENERAL SURGEONS IN THE SMALL TOWNS OF GEORGIA**
Davey Herring, M.D.
Medical Center of Central Georgia
Macon, Georgia

9:10 **Discussion**

9:15 **A BIOMECHANICAL ANALYSIS OF THE ANTERIOR TALOFIBULAR LIGAMENT**
Rick K. St. Pierre, M.D., William Hutton, M.Sc., Lamar L. Fleming, M.D., Thomas E. Whitesides, M.D.
Emory University School of Medicine
Atlanta, Georgia

9:25 **Discussion**

9:30 **PRESERVATION OF THE SPLEEN IN TRAUMA**
Kenneth Harper, M.D.
Medical Center of Central Georgia
Macon, Georgia

9:40 **Discussion**

9:45-10:00 **Break**

10:00-10:45 **NUTRITIONAL ASSESSMENT AND ALIMENTATION IN CANCER PATIENTS**
James L. Mullen, M.D.

10:45-12:15 **Members Papers**

10:45 **INTRAOPERATIVE THROMBOPHLEBITIS PROPHYLAXIS**
Thomas R. Nolan, M.D.
Atlanta, Georgia

10:55 **Discussion**

11:00 **MANAGEMENT OF GASTROSCHISIS IN A COMMUNITY HOSPITAL**
Robert D. Gongaware, M.D., Brenda Marino, M.D., Roberta Smith, M.D., Linda Sacks, M.D., J. V. Morrison, Jr., M.D.
Memorial Medical Center
Savannah, Georgia

11:10 **Discussion**

11:15 **RECONSTRUCTION OF BREASTS FOLLOWING MASTECTOMY BY SUBCUTANEOUSLY PLACED NATURAL-Y PROSTHESES**
William E. Schatten, M.D.
Atlanta, Georgia

11:25 **Discussion**

11:30 **A COMPARISON OF DIGITAL SUBTRACTION INTRAVENOUS ANGIOGRAPHY WITH STANDARD CAROTID ARTERIOGRAPHY TO EVALUATE THE CAROTID ARTERIES**
P. Stanton, M.D., P. Lamis, M.D., D. Rosenthal, M.D., W. Zeichner, M.D., C. Cioffi, M.D., T. Fuller, M.D., B. Jeffries, M.D.
Georgia Baptist Medical Center
Atlanta, Georgia
Medical College of Georgia School of Medicine
Augusta, Georgia

11:40 **Discussion**

11:45 **BILIARY ATRESIA — PROGRESS IN MANAGEMENT**
H. Gibbs Andrews, M.D., Daniel Caplan, M.D., G. T. Zwiren, M.D.
Emory University School of Medicine
Atlanta, Georgia

11:15 **Discussion**

12:00 **GASTRIC BYPASS OPERATION FOR MORBID OBESITY**
William M. Headley, M.D.
Milledgeville, Georgia

12:10 **Discussion**



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This report is the first to describe the administration of this drug immediately postpartum to contract the uterus in normal patients.

Use of 15-Methyl Prostaglandin $F_{2\alpha}$ Postpartum to Contract the Uterus in Normal Pregnant Women

GEORGE H. NELSON, PH.D., M.D., *Augusta**

Abstract

Three dosages, 62.5, 125, and 250 μg, of 15-Methyl $PGF_{2\alpha}$ have been administered intramuscularly immediately after delivery of the placenta to contract the uterus in normal patients at term. By three parameters, drop in postpartum hemoglobin and hematocrit, palpation of uterine tonicity, and measurement of lochia, there were no statistical differences among the three dosages in the efficacy to contract the uterus postpartum. The occurrence of gastrointestinal side effects is dose related.

It is our general impression that the uterus remained firmly contracted for several hours following administration of this drug. Along with oxytocin and ergonovine (or methylergonovine), 15-Methyl $PGF_{2\alpha}$ may prove to be an effective agent to prevent postpartum hemorrhage.

Introduction

PROSTAGLANDINS have been used postpartum for the treatment of uterine atony. Tagaki et al[1] reported on the use of intramyometrial $PGF_{2\alpha}$ in patients with postpartum hemorrhage. Jacobs and Arias[2] recently reported three patients unresponsive to conventional therapy, who were successfully treated in this manner. Hertz et al[3] described a patient with severe postpartum hemorrhage in whom PGE_2 vaginal suppositories were used. Carson and Bolognese[4] introduced the use of 15-Methyl $PGF_{2\alpha}$ for the treatment of uterine atony when they described its use in one patient with postpartum hemorrhage. Recently, Hayashi and Castillo[5] reported 13 cases of postpartum hemorrhage unresponsive to fundal massage, oxytocin, and methergine. Eleven were successfully treated with 250 μg 15-Methyl $PGF_{2\alpha}$ every 1.5 hours, and two patients required surgical intervention.

This report is the first to describe the administration of 15-Methyl $PGF_{2\alpha}$ immediately postpartum in normal patients to contract the uterus.

Materials and Methods

All patients were normal pregnant women near term with singleton fetuses and not at any particular risk of postpartum hemorrhage.

Immediately after delivery of the placenta, 90 patients received one of three doses of 15-Methyl $PGF_{2\alpha}$: Group I, 62.5 μg; Group II, 125 μg; Group III, 250 μg. There were 30 patients in each group, and all injections were given intramuscularly, except for one patient in Group II who inadvertently received the medication intravenously with no apparent untoward effects.

The first 75 patients (25 in each group) were assigned to groups in a double-blind fashion under protocol. The syringes were prepared by a registered pharmacist. There was 1 ml solution in each syringe, and the key to the number system was supplied to us by The Upjohn Company and was known only to the pharmacist. The last 15 patients were assigned as

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TABLE I — Maximum Percentage Drop in Hemoglobin in the First 24 Hours Postpartum, Medical College of Georgia, 1983

Group	No. of Patients	Mean ± S.D.	Maximum Percentage Drop in Hemoglobin Significance	< 10%	10% or >	Significance
				No. of Patients		
I	25	10.2 ± 7.5	I vs II NS*	13	12	I vs II NS
			I vs III NS			I vs III NS
II	24	13.0 ± 10.5	II vs III NS	11	13	II vs III NS
III	28	9.7 ± 6.5		14	14	

* NS = Not Significant.

TABLE II — Maximum Percentage Drop in Hematocrit in the First 24 Hours Postpartum, Medical College of Georgia, 1983

Group	No. of Patients	Mean ± S.D.	Maximum Percentage Drop in Hematocrit Significance	< 10%	10% or >	Significance
				No. of Patients		
I	25	10.0 ± 7.8	I vs II NS*	13	12	I vs II NS
			I vs III NS			I vs III NS
II	24	12.4 ± 10.4	II vs III NS	13	11	II vs III NS
III	28	9.8 ± 7.1		14	14	

* NS = Not Significant.

follows: patients 76-80, Group III; 81-85, Group II; 86-90, Group I. These patients were grouped under a different protocol. However, it was decided to combine similar data from both protocols in order to make the sample size larger.

Venous blood samples were drawn before delivery and 8, 16, and 24 hours postpartum. Hemoglobin measurements were made with a hemoglobinometer by the same individual. Hemotocrit determinations were done using an IEC microcapillary centrifuge.

Visual estimation of blood loss at delivery was not considered to be sufficiently accurate to be of any value in the evaluation of the efficacy of the three dosages to contract the uterus. Actual blood loss at delivery was measured in a few patients by the method recently described by Nelson et al[6] using a special plastic drape; however, these data are too few to be significant.

Vital signs, uterine tonicity (firm, medium, or boggy), and side effects were monitored every 30 minutes postpartum for 6 hours.

In some patients, we determined the amount of lochia lost from the time the patient was taken off the delivery table until 24 hours postpartum. In these patients, each preweighed sanitary pad or towel removed from the patient was individually placed in a plastic freezer bag, tightly secured, and kept in a second large plastic bag. These were weighed as soon as possible after the 24-hour period.

The data in Tables I, II, and IV were analyzed statistically using the analysis of variance. In Table III, the chi square test was utilized. Using the arc sine transformations of the percentage data in Table V, a one way analysis of variance showed a significant drug effect. Therefore, the Tukey-HSD procedure was applied to the nausea and/or vomiting and the diarrhea data.

Results

The efficacy of the three dosages to contract the uterus postpartum was compared in three ways:

(1) hemoglobin and hematocrit changes;

(a) the maximum percentage fall in hemoglobin and hematocrit was calculated by subtracting the lowest value obtained in the first 24 hours postpartum from the antepartum value, dividing by the antepartum value and expressing this as a percentage;

(b) the number of patients in each group was determined who had more than or less than a 10% drop in hemoglobin and hematocrit postpartum;

(2) the recordings of uterine tonicity by palpation during the first 6 hours postpartum; and

(3) the measurements of lochia during the first 24 hours postpartum.

The hemoglobin and hematocrit changes are presented in Tables I and II. In some patients, the hemoglobin and hematocrit values postpartum were higher than the antepartum measurement. These were considered as a zero percentage drop. The numbers of patients in each group who were excluded from inclusion in Tables I and II and the reasons for exclusion are as follows: Group I, five patients, three received oxytocin simultaneously with prostaglandin, one lacerated cervix, and one partially retained placenta; Group II, six patients, four received oxytocin simultaneously with prostaglandin, one 4th-degree perineal laceration which was repaired under general anesthesia, and one no

TABLE III— Uterine Tonicity Determined by Palpation, Medical College of Georgia, 1983

		PATIENTS			
		Recordings*			
Group	No. of Patients	All F	At Least 1 M	At Least 1 B	Significance
I	24	12 (50%)	10 (42%)	2 (8%)	I vs II NS†
II	24	12 (50%)	8 (33%)	4 (17%)	I vs III NS
III	27	18 (67%)	8 (33%)	1 (3%)	II vs III NS

			RECORDINGS			
			Recordings*			
Group	Total No.	No. Per Patient	F	M	B	Significance
I	281	11.7	260 (92.5%)	19 (6.8%)	2 (0.7%)	I vs II NS
II	275	11.5	255 (92.7%)	16 (5.8%)	4 (1.5%)	I vs III NS
III	314	11.6	284 (90.4%)	27 (8.6%)	3 (1.0%)	II vs III NS

* F = Firm, M = Medium, B = Boggy.
† NS = Not Significant.

TABLE IV — Postpartum Measurements of Lochia, Medical College of Georgia, 1983

Group	No. of Patients	Lochia Gm Mean ± S.D.	Significance
I	5	165 ± 84	I vs II NS*
II	7	177 ± 123	I vs III NS
III	10	145 ± 130	II vs III NS

* NS = Not Significant.

antepartum blood sample; Group III, two patients, one received oxytocin simultaneously with prostaglandin and one cervical and 4th-degree perineal laceration. Other patients also received oxytocin postpartum; however, it was administered at varying times after the prostaglandin and was given because the attending resident was of the opinion that the uterus was not contracting adequately and that the bleeding was heavy. These patients are included in the data in Tables I and II, and their numbers are as follows: Group I, three patients; Group II, two patients; and Group III, two patients.

The data on the recordings of uterine tonicity by palpation are shown in Table III. All patients who received oxytocin are excluded. It was felt appropriate to include the patients with the cervical and perineal lacerations and the partially retained placenta in Table III. While these non-prostaglandin related problems might contribute significantly to blood loss and, therefore, the data in Tables I and II, they should have no effect on the data recorded in Table III.

Table IV illustrates the measurement of lochia in 22 patients. No patients in Table IV received oxytocin or had significant lacerations. Collection of lochia began when the patient was removed from the delivery table and continued through 24 hours postpartum.

The only side effects attributable to the 15-Methyl $PGF_{2\alpha}$ were GI tract related and are listed in Table V.

Discussion

The currently approved drugs for contraction of the uterus postpartum inlcude: (1) oxytocin (a) 10-40 units added to 1000 ml of intravenous fluids and (b) 10 units given IM; (2) ergonovine (or methylergonovine) 0.2 mg IM and 0.2 mg oral tablets. The rate of intravenous infusion and the frequency of IM injections or oral tablets would generally depend upon the clinical evaluation of blood loss and uterine tonicity. At the present time, it would be impossible to state precisely the usefulness of 15-Methyl $PGF_{2\alpha}$ postpartum as compared to the currently available drugs. However, the present study does illustrate that 15-Methyl $PGF_{2\alpha}$ may be used in this manner, and it was the general impression of our resident and nursing staffs that the uterus remained firmly contracted for several hours following administration of this drug.

In centers where the principle method of administering an oxytocic agent postpartum is by intravenous infusion, the substitution of IM 15-Methyl $PGF_{2\alpha}$ might allow for discontinuance of IV fluids sooner and earlier ambulation of the patient. The main complaint from the nursing staff was the relatively high percentage of gastrointestinal side effects seen particularly with the higher dosages of the drug (Table V).

This study was designed to compare three dosages of 15-Methyl $PGF_{2\alpha}$ postpartum with respect to contraction of the uterus and side effects. The ability to contract and maintain a sustainedly contracted uterus and minimize postpartum bleeding was evaluated by three methods: (1) the drop in postpartum hemoglo-

TABLE V — Side Effects of 15-Methyl $PGF_{2\alpha}$, Medical College of Georgia, 1983

Group	No. of Patients	Patients with: Nausea and/or Vomiting	Significance	Diarrhea	Significance
I	30	0 (0%)	I vs II NS	3 10%)	I vs II NS
II	30	4 (13%)	I vs III P <0.05	5 (17%)	I vs III P <0.05
III	30	7 (23%)	II vs III NS	16 (53%)	II vs III P <0.05

NS = Not Significant.
P <0.05 = Significant at the 5% level.

bin and hematocrit; (2) palpation of the uterus; and (3) measurement of lochia. None of these methods showed any significant differences among the three dosages. In seven patients, the attending resident felt that the intramuscular 15-Methyl $PGF_{2\alpha}$ was not acting sufficiently fast and elected to administer intravenous oxytocin to contract the uterus. These seven patients were randomly distributed among the three groups.

Since it is the routine practice in our department to give some oxytocic agent postpartum, the inclusion of a "true" control group, i.e., one which received no "prophylatic" oxytocic medication, was not possible. We have studies currently underway comparing a single dosage schedule of 15-Methyl $PGF_{2\alpha}$ with an oxytocin-ergonovine control group.

Therefore, these data suggest that an intramuscular dose of 62.5 μg 15-Methyl $PGF_{2\alpha}$ is as effective as larger doses in the immediate postpartum period and produces significantly less gastrointestinal upset.

From these obviously preliminary data, I would like to make the following recommendations regarding future postpartum studies:

(1) Accurate measurement of blood loss should be made at delivery by the method[6] previously alluded to;
(2) Ideally, all study designs should have a "true" control group;
(3) Comparisons of IV and IM oxytocin, IM (and possibly IV) 15-Methyl $PGF_{2\alpha}$ and IM ergonovine should be made with regard to time required for the uterus initially to be recorded "firm" by the same investigator; and
(4) Comparisons of the duration of action of oxytocin, 15-Methyl $PGF_{2\alpha}$, and ergonovine should be done.

While the ultimate usefulness of 15-Methyl $PGF_{2\alpha}$ in the immediate postpartum period remains to be determined, continued investigation would appear to be in order.

Acknowledgments

The author is deeply appreciative to all of the following: (1) The Upjohn Company for their supply of 15-Methyl $PGF_{2\alpha}$ and their generous support of this study; (2) the OB-GYN Nursing Staff of Talmadge Memorial Hospital without whose help the study would have been impossible; (3) Harry C. Davis, M.S. Consulting Statistician, Division of Systems and Computer Service, Medical College of Georgia for his performance of the statistical analyses; (4) George A. Kemp, B.S. in Pharmacy, Assistant Director of Pharmacy, Talmadge Memorial Hospital, who prepared the syringes for the first 75 study patients; (5) and lastly, OB-GYN Residents, Clinton B. Ashford, M.D., Sylvester McRae, M.D., James R. Williamson, M.D., Osterman Cotes, M.D., Ravinder Jareth, M.D., and Charles Stafford, M.D., who managed the patients postpartum.

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These data suggest that the present public health warning system is effective in alerting health care personnel to potential health hazards in the state.

Changing Practices in the Use of Benzyl Alcohol-Preserved Solutions in Neonatal Intensive Care Units in Georgia

WILLIAM R. JARVIS, M.D., and R. KEITH SIKES, D.V.M., *Atlanta**

Abstract

After several investigators had traced a fatal syndrome in neonates associated with the receipt of benzyl alcohol-preserved solutions, the Food and Drug Administration and the Centers for Disease Control recommended discontinuing its use. Subsequently, Georgia hospitals with level 3 nurseries reported a significant reduction in the use of benzyl alcohol-preserved solutions for flushing intravascular catheters (8/10 vs 0/10, p = 0.00036), reconstituting medications (7/10 vs 0/10, p = 0.0015), and overall use (8/10 vs 0/10, p = 0.00036). These data suggest that the present public health warning system is effective in alerting health care personnel to potential health hazards. The present warnings resulted in the discontinuation of benzyl alcohol-preserved solution use in premature infants. This alteration in benzyl alcohol-preserved solution use should result in a decrease in mortality among critically ill newborns who receive parenteral therapy in Georgia.

BENZYL ALCOHOL has antibacterial properties and therefore has been used as a preservative in a number of intravenous solutions, including bacteriostatic sodium chloride and bacteriostatic water. Although it has caused toxicity in animals,[1] until recently no reports of adverse effects in humans have been reported. In January, 1981, Gershanik et al. reported a newly recognized gasping syndrome in premature infants associated with the receipt of benzyl alcohol-preserved solutions (BAPS).[2] Subsequently, Gershanik et al. and Brown et al. described 26 premature neonates, most of whom weighed ≤1250 grams, who developed metabolic acidosis, respiratory insufficiency, hypotension, and cardiovascular collapse leading to death.[3, 4] Further investigation led both authors to suspect that BAPS were responsible for the syndrome. All the infants had received BAPS when their intravascular catheters were flushed and when reconstituted medications were injected; all had elevated levels of urinary benzoate or hippurate or serum benzoic acid. Following these reports, the Food and Drug Administration (FDA) sent letters to health care personnel urging them not to use benzyl alcohol in premature infants,[5] and the Centers for Disease Control publicized these warnings in the *Morbidity and Mortality Weekly Report*.[6]

Since perinatal health is a major concern of the Georgia Department of Human Resources, we surveyed all hospitals with level 3 nurseries in Georgia about use of BAPS prior to and after the FDA/CDC warnings.

Materials and Methods

In November, 1982, a questionnaire was mailed to infection control personnel in all hospitals listed

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TABLE 1 — Surveyed Georgia Hospitals'* Use of Benzyl Alcohol-Preserved Solutions

	Before FDA Warning (Before June 1982)	*After FDA Warning (November 1982)*	*P-value†*
Flush intravascular lines	8/10 (80%)	0/10 (0%)	0.00036
Reconstitute medications	7/10 (70%)	0/10 (0%)	0.0015
Other purposes	1/10 (10%)	0/10 (0%)	0.5
Total	8/10 (80%)	0/10 (0%)	0.00036

* Georgia hospitals with level 3 nurseries.
† Fisher's exact test, one-tailed.

by the American Hospital Association as having neonatal intensive care units in Georgia. In February, 1983, a reminder with another copy of the questionnaire was sent to all who had not responded.

Results

Questionnaires were mailed to 21 Georgia hospitals; 18 (86%) returned a completed questionnaire. Ten of the 18 respondents reported having a level 3 nursery, and only these hospitals were included in the analyses (all nonrespondents were contacted by telephone, and none reported having a level 3 nursery). As shown in Table 1, two (20%) of 10 respondents did not use BAPS either before or after the FDA/CDC warnings. Eight (80%) used BAPS before the FDA/CDC warnings, but none used BAPS after the warning. All the major uses of BAPS, i.e. to flush intravascular catheters, to reconstitute medications, or other purposes, were eliminated after the FDA/CDC warnings. None of the Georgia hospitals with level 3 nurseries used BAPS in premature neonates for any purpose after the FDA/CDC warnings.

Discussion

The findings of our survey indicate that a dramatic change in the use of benzyl alcohol-preserved solutions has taken place in level 3 nurseries in Georgia since the findings of Gershanik et al. and Brown et al. were publicized.[2-6] Benzyl alcohol was initially added to solutions intended for intravascular administration because of its antibacterial, preservative properties. Upon administration, benzyl alcohol is oxidized to benzoic acid, which is conjugated with glycine in the liver and excreted as hippuric acid in the urine. The failure of the immature liver in the premature neonate to metabolize benzoic acid results in metabolic acidosis and an accumulation of benzoic acid. Many of the described adverse effects in these neonates with BAPS poisoning (respiratory failure, hypotension, convulsions) have been previously described in animals.[1, 7] Although the toxic effects of benzyl alcohol have been studied in animals and safe doses of benzyl alcohol for adults have been estimated (0.5 ml/kg),[1] neither toxicity in humans nor a safe dose level for neonates has been reported. The findings that large doses (99-234 mg/kg) of benzyl alcohol had been administered to the neonates with reported elevated levels of benzyl alcohol in blood and of benzoic and hippuric acid levels in urine[3] suggests that BAPS were indeed responsible for this fatal syndrome. Our survey shows that the FDA/CDC warnings were effective in eliminating BAPS use in premature neonates in Georgia. This dramatic cessation of the use of BAPS in level 3 nurseries in Georgia should result in a decrease in neonatal mortality in those nurseries.

Acknowledgement

We appreciate the assistance of Mr. David Smith.

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For a summary of product information, please turn the page.

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; shou these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood cou liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and afte diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutroper In peroral endoscopic procedures, coughing, depressed respiration, dyspnea hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal mu spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) onc daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initial increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal dai dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed an tolerated (not for use in children under 6 months). Capsules—1 capsule (15 daily when 5 mg oral Valium has been determined as the optimal daily dose (for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patie and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., an severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repe in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initial then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 m I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessa in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute interval to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind pos bility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, ge ally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prio procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes pr to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomato has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; empl general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® pack ages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxe containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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A distinct radiologic-pathologic appearance is described in a single case.

Atherosclerotic Subintimal Hematoma of the Carotid Artery

KENNETH ALONSO, M.D., F.A.C.P., S. L. MUHANNA, M.D., and S. K. NAIDU, M.D., *Stockbridge**

Abstract

A presumed new radiologic-pathologic entity of atherosclerotic subintimal hematoma has been described recently. Typical angiographic appearance is that of sharp margination, rounding, with an eccentric filling defect located near the extracranial carotid bifurcation. Spontaneous rupture of small vascular channels within the atheromatous plaque has been proposed as the etiology of the lesion. A single case is discussed below, and angiographic and pathologic findings are reviewed.

THE ULCERATED CAROTID ARTERY plaque is a well recognized entity. Cerebral infarction or cerebral thromboembolism manifest as a transient ischemic attack is associated with the lesion.[1] A presumed new radiologic-pathologic entity of atherosclerotic subintimal hematoma has been described.[2] It is claimed that subintimal hematomas have been found at the carotid bifurcation in a high percentage of patients operated on for repeated transient ischemic attacks in a single hemispheric distribution. One third of the lesions were associated with ulceration. The typical angiographic appearance is that of sharp margination, rounding, with an eccentric filling defect, and a location near the extracranial carotid bifurcation. This paper briefly presents the single case among 40 carotid artery surgical procedures for transient ischemic attack in a 3-year period in a suburban community hospital.

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Case Report

The patient was a 61-year-old white man, a truck driver. He experienced loss of consciousness and development of left sided weakness 5 days prior to his hospital admission. He had experienced dizzy spells and blackouts while driving 3 months earlier. Extensive investigation following the episode of dizzy spells and blackouts failed to disclose pathologic evidence of disease. With readmission following the development of left sided weakness, the patient was found to be mildly hypertensive (140/90mmHg). Physical examination was unrevealing. An electrocardiogram demonstrated normal sinus rhythm and presented changes compatible with an old myocardial infarction. CT scan of the head again failed to demonstrate a mass lesion or area of infarction. Transfemoral carotid arteriography was performed. Figure 1 shows the angiogram demonstrating sharp margination, rounding, with an eccentric filling defect located near the extracranial carotid bifurcation on the right. The left carotid showed no evidence of disease. The patient underwent endarterectomy with removal of the plaque. Figure 2 shows the ulcerated plaque. The lumen is narrowly patent. It also demonstrates hemorrhage in the wall of the plaque. The patient's symptoms remitted following surgery.

Discussion

The pathophysiology of transient ischemic attacks has been shown to be related to the ulcerated plaques of the carotid bifurcation with symptoms produced by embolization of intracranial arteries by the dislodging of atheromatous material and/or platelet clots.[1, 3] Edwards[2] believes that the subintimal hemorrhage described is likely the result of spontaneous

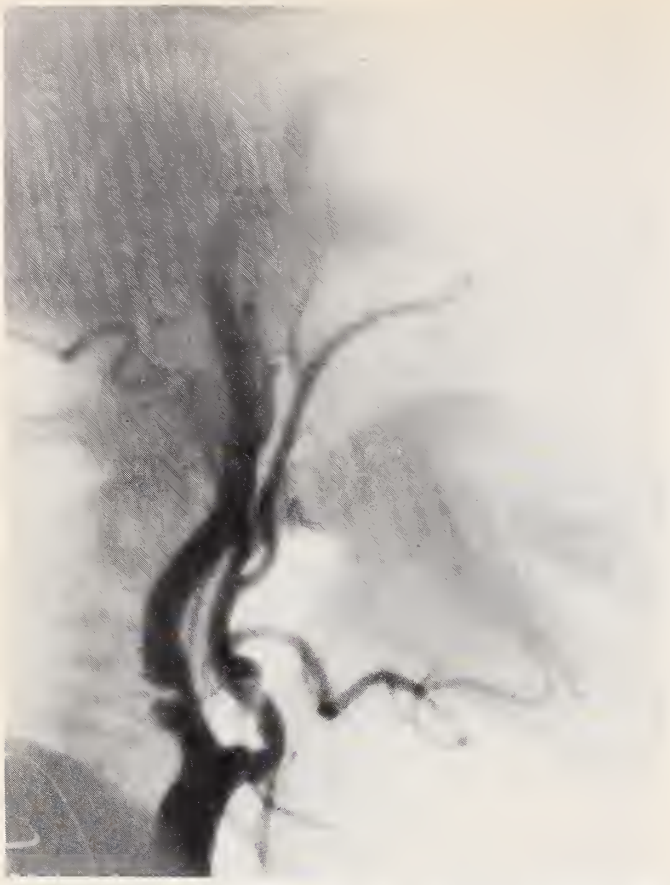


Figure 1 — Carotid angiogram demonstrating sharply marginated, rounded lesion with an eccentric filling defect near the extracranial carotid bifurcation.



Figure 3 — H&E 100x. Section through plaque demonstrating intact intima, multiple vascular channels, and hemorrhage.



Figure 2 — Ulcerated plaque. Hemorrhage is present in the wall.

rupture of small vascular channels within the atheromatous plaque rather than the result of partial dissection originating in the base of an ulceration. Once bleeding occurs, symptoms may result from a sudden increase in plaque size with consequent luminal narrowing as well as from embolization of atheromatous material so dislodged. Figure 3 shows a microscopic section through the plaque. Remote hemorrhage is demonstrated histologically. Small vascular channels are found in the plaque. Dissection is unlikely because of the limited area of the ulceration of the plaque and the finding of hemorrhage principally away from the area of ulceration.

Hemorrhage into the wall of the plaque is not an unusual finding.[4] Intramural hematoma has been demonstrated by others.[5] However, there are no other reports which purport to demonstrate a high percentage of subintimal hemorrhage in plaques in patients with focal symptoms of transient ischemic attacks or cerebral infarction in the absence of preexisting trauma other than that by Edwards describing the radiologic-pathologic entity.[2]

Subintimal hemorrhage into a plaque is another mechanism of stroke probably related to acute reduction in the blood flow to the brain due to luminal narrowing in the internal carotid artery. A distinct radiologic-pathologic appearance has been described. The lesion is not common.

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The use of a tracer which remains in the circulation permits serial imaging after injection and may lead to the detection of intermittent gastrointestinal bleeding.

Arteriovenous Malformation of the Colon: Localization With Scintigraphy

KENNETH ALONSO, M.D., F.A.C.P., MICHAEL PODOBNIKAR, M.D., A. M. MAYS, M.D., and S. K. NAIDU, M.D., *Stockbridge**

THE SOURCE of intermittent gastrointestinal bleeding may be difficult to locate since angiography or endoscopy will show hemorrhage only at the time of bleeding. Angiodysplastic lesions vary greatly in size but rarely exceed a few millimeters in diameter. Because they do not protrude appreciably into the lumen of the bowel, they are extremely difficult to display by conventional diagnostic methods. The distribution in the colon is usually right sided.[1]

Selective mesenteric angiography with rapid sequential filming has been recommended to demonstrate these lesions.[2] The use of a tracer which remains in the circulation permits serial imaging after injection and may lead to the detection of intermittent gastrointestinal bleeding. It is also noninvasive. We report a case of intermittent bleeding detected only with scintigraphy and demonstrating arteriovenous abnormalities histologically.

Case Report

The patient was a 77-year-old black man with a history of repeated gastrointestinal bleeding. He was hypertensive, diabetic, and blind in one eye from glaucoma. His cardiac rhythm was atrial fibrillation. One leg had been lost to gangrene. At this particular admission endoscopy was normal. Selective mesenteric angiography with rapid sequential filming failed to demonstrate a lesion (Figure 1). The patient continued to show a fall in hematocrit with persistence of guaiac positive stools. A bleeding scan was performed by taking patient red cells, incubating them with 99m-Technetium as the pertechnetate ion for 15min at room temperature, and reinjecting the tagged mixture. This was then followed with cold pyrophosphate. The abdomen was imaged over time. Focal collection of nuclide was demonstrated near the splenic flexure and increased with time (Figure 2). Imaging of the liver, the vascular pool, and the stomach is a technical problem with the method.[3] The patient agreed to surgery, and a partial colectomy was performed. Figure 3, the post-



Figure 1 — Selective angiogram demonstrating little colonic vessel abnormality.

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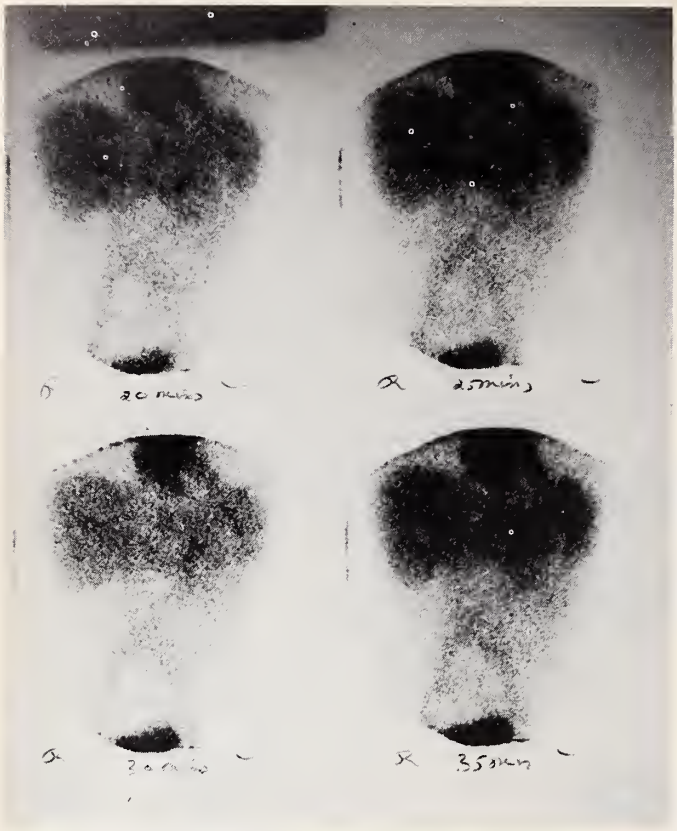


Figure 2 — Pre-operative Technetium bleeding scan demonstrating persistent uptake at the splenic flexure.



Figure 3 — Post-operative Technetium bleeding scan demonstrating absence of uptake in area of splenic flexure. (Compare with pre-operative scan shown in Figure 2.)

operative bleeding scan, is provided for comparison. Figure 4 is the specimen photograph demonstrating an area of punctuate hemorrhage near the splenic flexure. Specimen radiographs disclosed a suspicious area of vascular tufting at a single point, the site of hemorrhage. Histologic examination was performed on tissue obtained at that point. The patient did well following this surgical procedure. His anemia has not recurred.

Figure 5 is an area of vascular prominence noted in colonic submucosa at the area of hemorrhage. Arteriovenous channels are seen. Other sections demonstrate telangiectasis of submucosal capillaries with associated hemorrhage in the bowel lumen.



Figure 4 — Hemicolectomy specimen with punctate hemorrhage at splenic flexure.

Discussion

Some patients with obscure gastrointestinal bleeding are found to have angiodysplastic lesions of the bowel. Surgical resection of these lesions has long been considered curative. The cause of these lesions is not known. It is unclear whether angiodysplasia is a congenital or an acquired condition. The true prevalence is not known. If demonstrated angiographically early venous filling and a vascular tuft may be seen. In patients with chronic gastrointestinal bleeding, demonstration of an arteriovenous malformation is a strong indication for surgery. Unexplained intestinal bleeding after resection of the arteriovenous malformation has been described.[2]

Both 111-Indium and 99m-Technetium labelled red cells have been employed in imaging. The shorter half-life of technetium, the secretion of pertechnetate into the stomach and bowel as demonstrated in these images, and the high elution rate of Technetium from the red cell favor the use of Indium as an imaging agent.[4] Indium was not readily available at the time these studies were performed, however. The use of alternative imaging vehicles such as the sulfur colloid with Technetium will minimize background problems such as are demonstrated in this case.[5] Their drawback, however, is the short time in circulation and the obvious necessity of injecting the agent at the time of brisk active bleeding. That drawback is shared with angiography.

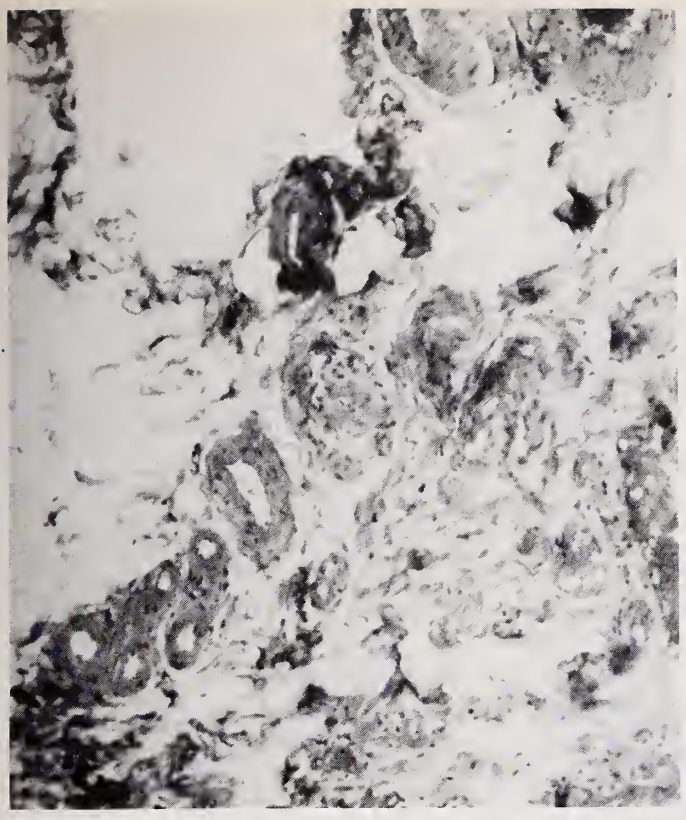


Figure 5 — H&E 100x. Vascular prominence in submucosa at bleeding site.

The bleeding scan which employs a tracer that remains in circulation long enough to permit repeat imaging is an approach to detect the site of intermittent gastrointestinal bleeding. The attractiveness of the procedure is enhanced by its non-invasive character.

Summary

The source of intermittent gastrointestinal bleeding may be difficult to locate since angiography or endoscopy will show hemorrhage only at the time of bleeding. The use of a tracer which remains in the circulation permits serial imaging after injection and may lead to the detection of intermittent gastrointestinal bleeding.

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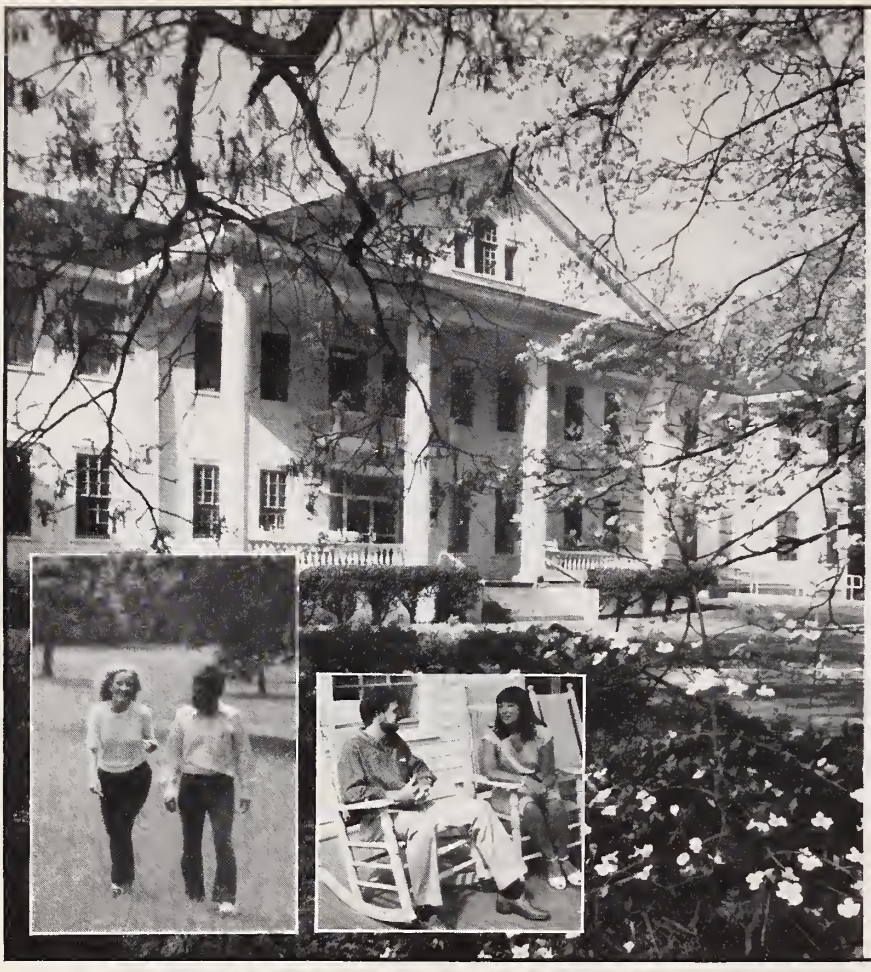
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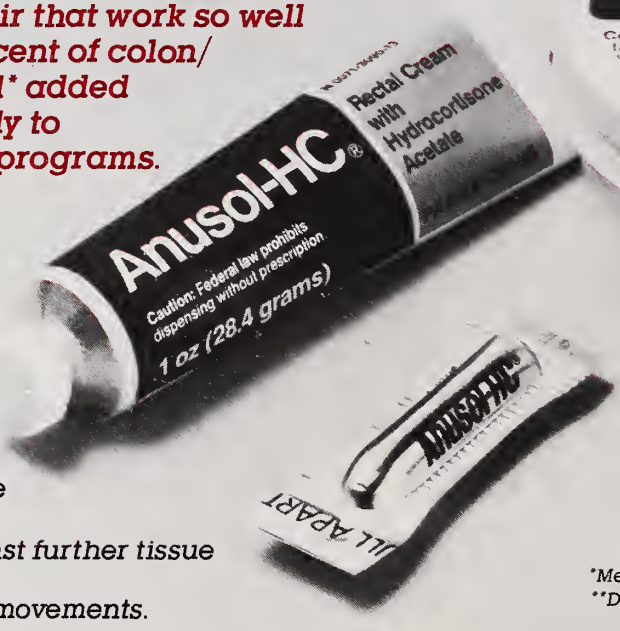
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Please see opposite page for brief summary of prescribing information.

**Meeting of Am Soc Colon/Rectal Surgeons, May 1980*
***Data on file, Marketing Research Dept, Parke-Davis*

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- ☐ *Soothes, cools, comforts, and cleanses irritated anorectal areas.*

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Hemorrhoids and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0 mg; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy: See "WARNINGS"

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
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*Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237.

Please see summary of product information on reverse page. ROCHE®

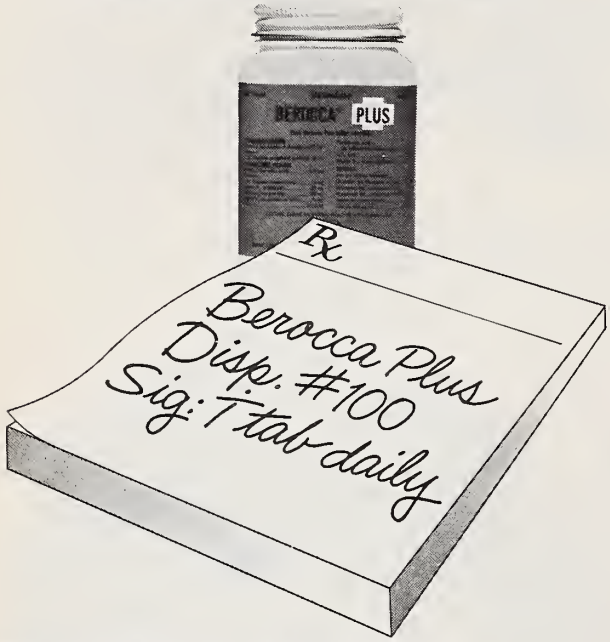
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Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets — bottles of 100.

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RU-TUSS® II

sustained release capsules

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage In pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated intestinal obstruction, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis histeria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patien' should be induced to vomit, even if emesis has occured spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

HOW SUPPLIED: Green and clear capsules with green and white beads. Bottles of 100 tablets. NDC 0524-0031-01

Store at controlled room temperature 15-30°C (59°-86°F.).

CAUTION: Federal law prohibits dispensing without prescription.

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editorial
editorial
editorial

Your Money — Your PAC

In late October or early November, you will receive a statement for your county medical society, MAG, and GaMPAC dues. These appear on a joint statement.

The purpose of this editorial is to explain the GaMPAC portion of the statement and to stress the importance of including the GaMPAC portion in your payment. (Elsewhere in this issue of the *Journal* are articles about PACs by Congressman Newt Gingrich and Lt. Governor Zell Miller.)

Listed below are some of the most frequently asked questions about GaMPAC.

1. *What is GaMPAC?*
 Georgia Medical Political Action Committee, GaMPAC, is a voluntary committee comprised of Georgia physicians who contribute funds to aid in the election of Georgia candidates for the Georgia Legislature and congressional candidates whose philosophy is similar to the medical profession.
2. *Do other state medical associations have PACs?*
 GaMPAC is one of 50 state medical PACs and the District of Columbia connected with AMPAC, the political action committee of the AMA. Both organizations are bipartisan.
3. *What is the purpose of GaMPAC?*
 A. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.
 B. To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records, officeholders, and candidates for elective office.
 C. To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.
4. *Do I, a member of GaMPAC, have a say so in which candidate receives GaMPAC support?*
 Yes, the by-laws of GaMPAC state: "There will be no contribution made unless there has been a request in writing from a Georgia physician seeking support for a candidate of his choice."
5. *Who ultimately decides on contributions?*
 There is a Board of Directors made up of two medical doctors and one auxiliary member from each of Georgia's 10 Congressional districts. From these 30 persons is elected an Executive Committee of five medical doctors and one auxiliary representative. When possible, candidate support requests go before the Board. In between Board meetings, the written requests go before the Executive Committee.
6. *Who presents the contribution to the candidate?*
 A local physician (or physicians) personally presents the contribution to the candidate. This informs the candidate that GaMPAC represents physicians in his area along with other medical doctors throughout Georgia.

7. *What are the dues?*
 A 1-year sustaining membership is $150. This membership includes both the physician and the spouse.
8. *Can GaMPAC dues be paid by professional corporation checks or personal checks?*
 Georgia law permits GaMPAC contributions to be paid by *either* personal or professional corporation checks.
9. *Do GaMPAC contributions qualify for a tax credit?*
 Yes, if your contribution is paid by personal check it qualifies for a tax credit as a portion of your political contribution for that year.

This should answer the majority of your questions about GaMPAC, however, if you have any additional questions, feel free to call me in Macon at 912/745-8581 or Rusty Kidd at the MAG Headquarters office 404/876-7535 or INWATS 800/282-0224.

Now for the Sales Pitch!

We need you as a 1983-84 GaMPAC member. With your help we can have a significant voice in who is elected and/or defeated in the 1984 State House of Representatives, State Senate, and the U.S. House of Representative races in Georgia.

Last election year, GaMPAC was one of the largest contributors in Georgia. We did this with less than 15% of Georgia physicians as GaMPAC members. Imagine what our impact would be if we had 100% participation! The results of our contributions and who we helped get elected would guarantee us the opportunity to voice our concerns about medicine to each and every elected official.

Only your willingness to help by joining now on your dues statement can enable us to have the desired results in 1984.

Please make a mental note to join for 1983-84 and inform your secretary of your desire to be a GaMPAC member.

Thank you in advance for your willingness to have a voice in the 1984 elections.

Beverly B. Sanders, Jr., M.D.
Chairman, GaMPAC
Macon

Preferred Provider Organizations: A Preview of Likely Legal Issues

RONALD F. WRIGHT, *Atlanta**

In a health care industry filled with PSROs, PROs, HMOs, IPAs, and other acronyms, Preferred Provider Organizations (PPOs) may offer a way for physicians to take part in contractual health care without losing the fee-for-service concept or a reasonable amount of control over the physician-patient relationship. Yet, it is not exactly clear at this time what constitutes a PPO — or, more accurately, it is clear that a number of different types of organizations can constitute a PPO. PPOs can be corporations, partnerships, joint ventures, or other types of entities; they can be sponsored by underwriters, providers, administrators, employers, or others; they can provide health care services, perform administrative services, underwrite a health care plan, or all of the above.

This article briefly describes some of the major organizational and functional characteristics of PPOs. It also highlights the potential legal issues likely to arise out of the formation and operation of PPOs.

What Is a PPO?

First, what is a PPO? Generally, PPOs bring together physicians and large groups of patients, usually represented by a single employer or insurer. Often a hospital or a group of hospitals also will take part in the arrangement.

Beyond this general description, however, the concept of a PPO may vary widely, depending upon the particular health care functions performed and, in part, upon the legal structure adopted. In that regard, it may be helpful to conceptualize a PPO as a form of prepayment package, comprised of various components: a provider component (the physicians and hospitals), an administrative component (those performing utilization review and other administrative functions), and an underwriting component (the third-party payer). These components might be integrated through a series of contractual arrangements; alternatively, coordination of components might come from a sponsoring insurance carrier or third-party payer, or even from a sponsoring group of hospitals or physicians.

Taking one typical PPO case, a group of physicians and the representative for a large group of patients (an insurer or self-insured employer) might commence negotiations with one another for the purpose of entering into a contractual arrangement involving several important issues: First, there may be a negotiated fee schedule, pursuant to which the physicians might agree to provide services at a reduced cost. There may also be some form of utilization review; for example, the physicians might promise to limit their provision of services to those which are

*Prepared at the request of the Medical Association of Georgia. Mr. Wright attends Yale Law School and is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

reasonable and necessary, a promise enforced by some formal method of utilization review making each physician accountable for the amount of testing and other services provided. As consideration for these promises, the third-party payer might agree to pay the physicians promptly, such as within 10 days; the third-party payer might also institute an incentive system (e.g., reduced co-payments or deductibles) designed to encourage patients to seek health care services from the preferred providers. As a result, although technically not part of the agreement, the physicians may benefit from the increased number of patients seeking their services.

Many different forms of organizational structure are available for PPOs. A PPO might be incorporated as a separate legal entity, or operate as a partnership, or it might merely consist of a series of contractual relationships among participants. In part, the decision as to the type of organizational structure utilized by a PPO will depend on the functions to be performed; that is, one form of organizational structure may be particularly appropriate for the functions intended to be performed by a particular type of PPO.

At the same time, the decision on the type of organizational structure selected for a PPO will also depend on the legal consequences likely to result from the type of organizational structure selected. As discussed below, some parts of the law (such as the antitrust laws) call for greater formalization and integration of the organization; alternatively, other parts of the law (such as that dealing with tort liability) make a more dispersed arrangement more beneficial.

The remainder of this article looks at some of the legal issues that are likely to arise in connection with the formation and operation of PPOs and, in particular, discusses how the choice of organizational structure may affect the resolution of those legal issues.

Potential Antitrust Issues Involving PPOs

It is now clear that the antitrust laws apply to health care much in the same way that they apply to any other industry. As a result, the formation and operation of a PPO carries with it certain risks, primarily because it provides an opportunity for competing physicians to decide together what price to charge a customer (or a third-party payer), an activity which under certain circumstances could be viewed as unlawful price fixing.

Last year in *Arizona v. Maricopa County Medical Society*,[1] the United States Supreme Court considered whether the antitrust laws prohibited an agreement among competing physicians to set, by majority vote, the maximum fees that they would claim in full payment for health services provided to policy holders of specified insurance plans. The *Maricopa* opinion, because it reviewed a system that resembles a PPO in several important ways, might become a controlling precedent on the question of whether PPOs engage in illegal price fixing.

The Court ruled that the agreement to abide by maximum fee schedules was illegal *per se*. By illegal *per se*, the Court meant that the dangers of manipulating prices at all (even by setting *maximum* prices) were so overwhelming that the activity should be prohibited without fully considering all of the positive and negative effects on competition or the motives or intentions of the parties; in essence, the existence of the agreement, by itself, was sufficient to establish an antitrust violation.

The alternative to *per se* treatment is called the "Rule of Reason." Under the Rule of Reason, a court considers all the economic arguments both for and against the activities in question, together with the intentions of the parties engaging in the activities. A PPO could probably survive an analysis under the Rule of Reason, since its price setting and other activities presumably would have a procompetitive influence on the market, so long as other physicians or physician-groups competed with the PPO. On the other hand, the *per se* treatment used in *Maricopa* might lead a court to conclude that PPOs are simply a method by which a group of competing physicians engaged in unlawful price fixing.

There are no cases to date analyzing PPOs under the antitrust laws, so it is

unclear at present exactly how a court would analyze the formation or operation of a PPO under the antitrust laws. Nonetheless, the *Maricopa* opinion itself suggests that two different forms of PPOs might best resist charges of price fixing. The first is a "highly integrated" PPO. The Court in *Maricopa* found it significant that the group of physicians involved was not a partnership or other joint venture in which competitors pooled their capital and shared the risks of loss or profit. Such integration could transform conspiring competitors into a single entity competing with other sellers in the market, enabling it to set a single price for all of its members. The amount of such integration necessary to avoid liability remains unclear, but the more completely the doctors' practices become involved in the PPO (i.e., the more the physicians are "at risk"), the less the risk of antitrust violations. Integration appears to be the best escape from antitrust liability, so long as an organization does not get so large that it possesses an unduly large amount of market power.[2]

The second type of PPO organization best able to survive an antitrust challenge is the complete opposite of an integrated PPO. Individual doctors may each contract with the same PPO regarding the fees he or she will charge to covered patients. This converts the agreement from a horizontal agreement among competing doctors to a vertical agreement between the PPO and each individual doctor, and makes the Rule of Reason the proper method for evaluating charges that the agreement violates the antitrust laws.

In addition to price fixing, there may be other antitrust problems encountered by a PPO. For example, illegal boycotting has become a common claim among physicians denied staff privileges at hospitals, and the same claim might be made by physicians and others with whom a PPO refuses to deal (i.e., that the PPO unlawfully prevented a physician from becoming a member, thereby preventing the physician from obtaining the economic benefits arising out of PPO membership).

Similarly, a group of competing physicians joining together to make profitable arrangements with an insurer might seek to prevent the insurer from agreeing with another physician, or they might refuse to refer business to another physician. In these cases, the excluded physician might claim that he or she has been boycotted.

Potential Contract Law Issues Involving PPOs

The contractual arrangements that make a PPO work may raise some interesting issues of interpretation under general principles of contract law. In particular, those physicians entering PPOs should be wary of some of the most burdensome arrangements likely to arise in the formation or operation of a PPO.

PPOs, like most alternative health care systems, increase the opportunities for physicians to control each other's practices. With this in mind, physicians will want to avoid contracts which prevent them from treating patients other than those participating in the PPO. "Gatekeeper PPOs" should raise the most suspicion, for in that type of organization the first physician to see a patient may only refer that patient to a specialist within the organization. A commitment to refer patients only to specialists within the PPO might at times conflict with the physician's own best judgment regarding the specialist most qualified to treat a patient. Extreme cases of this sort might even lead to tort liability, such as for negligence or malpractice in not referring the patient to an appropriate specialist.

PPOs also give patients and third-party payers an opportunity to control a doctor's practice. Insurers and other third-party payers usually agree to reimburse a patient only for the "customary and usual" charges of a doctor. Once a physician joins a PPO and negotiates a discounted fee for patients covered under the plan, in subsequent negotiations with the insurer, the insurer might consider the discounted fee to be the new customary and usual fee and use that as its baseline for any further negotiations. Moreover, if a physician continues to accept patients other than those covered under the PPO plan, the insurer of those patients might only recognize the discounted fee as the customary and usual fee, and the lack of coverage may make patients unwilling to accept undiscounted fees.

It is also conceivable that patients might obtain the right to continued treatment under a PPO agreement. While the usual doctor-patient relationship may be terminated with relative ease by either party, the contract under a PPO exists between the doctor and the insurer or the administrative body which operates the plan. In that situation, the doctor might not be free to stop treating a patient without breaking the agreement with the insurer or administrator and losing all patients covered by the plan.

Potential Tort Liability Issues Involving PPOs

The tort liability of a hospital for the negligence of physicians using its facilities turns on general principles of agency law. In order for the hospital to be liable for the mistakes of a physician, the physician must be an employee of the hospital rather than an independent contractor. Where the physician is an employee of the hospital, his or her negligence is imputed to the hospital. While liability for the acts of independent contractors is more limited, a hospital may still be liable for negligent selection of the independent contractor, such as by the improper granting of staff privileges to an unqualified physician. Negligent oversight or review of a physician's work might also lead to liability once the hospital undertakes such a task.

While it is still speculation, tort liability for a PPO might proceed along the same lines as liability for a hospital. These principles of liability extend to professional corporations, and the analogy to a PPO comes easily. If agency principles do apply, the precise relationship between the organization and the doctor will be of extreme importance. In contrast to the incentives under antitrust law, tort law encourages a decentralized organization; only if the negligent physician is an independent contractor will the PPO avoid liability. Thus, the greater the autonomy and control over the work exercised by a physician, the less likely the inference that he or she is an employee in the PPO.

Notes

1. 102 S.Ct. 2466 (1982).
2. The Federal Trade Commission has confirmed that the size of a PPO will be of utmost concern. See, Opinion letter to Health Care Management Associates, June 7, 1983.

References continued from page 733.

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Nonpharmacologic Treatment of Hypertension

LAURENCE O. WATKINS, M.D., M.P.H., *Augusta**

THE RESULTS of randomized controlled trials, such as the Australian Mild Hypertension Trial[1] and the Hypertension Detection and Follow-up Program,[2] have revealed that the treatment of mild hypertension reduces cardiovascular morbidity and mortality. However, the benefits of blood pressure reduction were obtained by the prolonged use of drugs, many of which have potentially harmful side effects. The results of the Multiple Risk Factor Intervention Trial have raised the question that diuretic therapy, at least in some individuals, might have harmful effects.[3] Thus, some physicians are understandably reluctant to commit patients to lifelong therapy with antihypertensive drugs, some of which are both expensive and potentially noxious. These developments have led to renewed interest in the nonpharmacologic therapy of hypertension.[4] Some forms of nonpharmacologic therapy have been proposed as alternatives or adjuncts to drug therapy. There is evidence that weight reduction, reduction of salt intake, and increased physical exercise can safely and effectively reduce elevated blood pressure. There is also accumulating evidence that different forms of behavioral therapy are effective.

Weight Reduction

Obese individuals tend to have higher blood pressures than the nonobese, and weight gain is often associated with increase in blood pressure. In hypertensive individuals, weight loss is often associated with reduction of blood pressure.[5] For example, in a study by Reisen et al,[6] a 20-pound weight loss in hypertensive subjects was associated with a mean decrease in blood pressure of 26/20 mm Hg. In this study, blood pressure reduction was associated with weight reduction independent of salt intake. In the Chicago Coronary Prevention Evaluation Program, Stamler et al[7] followed 115 men with definite mild hypertension and 101 men with high-normal diastolic blood pressure. The majority of these men were 15% or more overweight initially. Sustained weight loss, about 5-6% of body weight, over 5 years of followup was achieved by 63% of the men, 11.7 pounds on average by those who were hypertensive and 10.5 pounds by those normotensive. This was associated with a blood pressure decrease of 13/10 and 7/4 mm Hg in these two subgroups, neither of which required antihypertensive drug therapy. The mechanism for the decrease in blood pressure associated with weight loss appears to be primarily a decrease in cardiac output. The marked blood pressure reduction

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Articles for this "Page" are sponsored and approved by the American Heart Association, Georgia affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

(approximately 1 mm Hg per pound) which can be produced by weight loss suggests that this is a very effective method for nonpharmacologic treatment of blood pressure. Though it is sometimes difficult for patients to maintain the long-term changes in eating and exercise habits which are necessary to produce moderate sustained weight loss, physician's efforts to foster this appear to be enhanced if patients are referred to dietitians.

Salt Restriction

Cross-cultural studies reveal a relationship between average sodium intake in the population and the prevalence of hypertension or the mean blood pressure level.[8] Within single populations, it has been more difficult to establish a relationship between sodium intake and blood pressure.[9] It appears that one of the reasons for this is that individuals differ in their susceptibility to the effects of dietary sodium.[10] It has been suggested that restriction of sodium intake to levels of about 3 grams per day (range of 2-5 grams) might be effective in decreasing the prevalence of hypertension.

Before antihypertensive drugs became available, hypertensive vascular disease was treated with diets such as the Kempner rice diet which contained very low levels of sodium, about 10 mmol/day.[11] However, such a diet requires special foods, and even for a compliant patient would be difficult to ensure. A recent double-blind randomized crossover trial of moderate sodium restriction in unselected patients with mild to moderate essential hypertension has confirmed that moderate sodium restriction is an effective method of blood pressure reduction.[12] A group of 19 patients with an average blood pressure of 156/98 mm Hg was instructed to restrict sodium intake by not adding salt to food and by avoiding foods loaded with sodium. On the sodium-restricted diet, during treatment with a placebo, the mean blood pressure decreased to 144/92 mm Hg. In the crossover phase of the trial, the placebo tablets were replaced by tablets containing an amount of sodium estimated to restore each subject's sodium intake to the usual level. After 4 weeks of this therapy, the blood pressures rose to a level not significantly different from the initial blood pressure, 154/97 mm Hg. This carefully designed trial has confirmed the beneficial effect of salt restriction on blood pressure. In addition to reducing blood pressure, moderate sodium restriction enhances the effect of diuretic therapy.[13]

Exercise

There is renewed interest in the potential for using physical training to treat subjects with hypertension. It is known that adults who are physically fit have lower blood pressures and are less likely to develop hypertension than those whose lifestyle is sedentary.[14] A few small studies have demonstrated blood pressure reductions in groups of patients who have undertaken aerobic exercise training. For example, Choquette and Ferguson[15] observed decreases of resting blood pressure of 15/8 mm Hg in a group of 37 subjects with borderline hypertension. The beneficial effects of exercise on subjects with more severe hypertension are less obvious. Further studies in this area are being undertaken. Though the data do not indicate a clear beneficial effect of exercise in *all* subjects, exercise is often an essential component of programs intended to produce weight loss in obese subjects.[7, 16]

Behavioral Methods

Biofeedback, relaxation, psychotherapy, and environmental modification have been shown to decrease blood pressure.[17]

Biofeedback: Biofeedback employs instrumentation to provide subjects with information about physiologic processes which are controlled by the nervous system, but which are not accurately perceived without such "feedback." Commercially-available devices are used to present electromyographic information as lights, tones, or meter readings.[18] The provision of this information allows for trial-and-error learning and the attainment of control over the physiologic pro-

cesses. It has been possible to train *normotensive* subjects to decrease their blood pressures by 5-17 mm Hg at a single training session using biofeedback. *Hypertensive* subjects have been taught to decrease their systolic pressures in a similar manner, but with the use of repeated sessions. Typically, subjects are trained for about 30 minutes, each minute of feedback being followed by a minute of rest. One or two sessions may be used each day, and various incentives have been used. Some investigators have observed decreases in blood pressures measured at home, of 18/8 mm Hg in small numbers of subjects. It is clear that some individuals receive prolonged benefit, but it is not yet known whether this method will be generally applicable. Use of biofeedback requires continued practice, and the problems of compliance are likely to be as great as those observed in connection with pharmacologic therapy.

Relaxation Methods: The purpose of training in relaxation is to elicit a calm, hypometabolic state which is associated with decreased sympathetic arousal and heightened activity in the supraoptic and preoptic areas of the anterior hypothalamus. Several relaxation techniques are available, some of which are variations of meditation techniques.[18] Many studies with small numbers of patients have been reported. The most impressive of these is a randomized trial of hypertensive men identified by a screening program who were not treated with drugs and who were assigned either to relaxation therapy or to no treatment. In this study, Patel et al[19] observed that the treated group (initial blood pressure 163/100 mm Hg) sustained a 22/12 mm Hg reduction, while the untreated group (initial blood pressure 160/100) sustained an 11/3 mm Hg reduction after 6 months. Southam et al[20] have observed similar encouraging results and have confirmed that the tendency to a lower blood pressure after relaxation therapy persists after training is discontinued and can be detected during a typical workday. Agras[21] has concluded that relaxation therapy can be recommended for patients whose blood pressure has not been adequately controlled by medication. He estimates that about 60% of such subjects will have the blood pressure brought under adequate control if relaxation therapy is added to a drug regimen, 30% will have some reduction though the blood pressure will still be above normal limits, and about 10% will not benefit at all, either because they cannot learn to relax or because relaxation does not reduce their blood pressure. Relaxation may be particularly useful in borderline hypertensives and may obviate the need for pharmacologic therapy.[22] Though it is possible for patients to teach themselves techniques of relaxation (through the use of written instructions or tapes), effective learning often requires supervision. Referral of patients to clinical psychologists trained in this technique is often necessary if the therapy is to be effective.

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Genitourinary Tumors II: Carcinoma of the Prostate

SAM D. GRAHAM, JR., M.D., *Atlanta**

CARCINOMA OF THE PROSTATE is the most commonly occurring malignancy of the adult male genitourinary tract. Overall, it is the third most common cause of mortality from cancer death in males, accounting for 21,674 deaths in 1978.[1] Eighteen percent of all malignancies in adult males will be carcinoma of the prostate. As with most genitourinary tumors, the incidence of prostate cancer increases with age. This is evident in autopsy studies which show up to 80% incidence of carcinoma of the prostate in males over the age of 80. A bias in distribution among races has been reported in that blacks in some studies have a significantly higher incidence of carcinoma of the prostate than whites. Secondly, the survival statistics show white patients having approximately 63% survival overall versus 51% among black patients. It is unclear as to why these differences exist.

The causes of prostate cancer are unknown. Attempts to relate prostatic carcinoma to variety of sexual partners, coital frequency, or exposure to patients with cervical cancer have yielded no clear cut results. Attempts to isolate viruses, virus titers, and ultrastructural studies have yielded no firm basis for the viral theory of prostate cancer. Another hypothesis has been the hormonal profile of the patient as a cause of carcinoma of the prostate. The data is based on the fact that no prostate cancer patient has been found in eunuchs and that latent prostate cancer is less frequent in patients who are cirrhotic with hyperestrogenism. Some epidemiologic data would suggest that prostate cancer patients typically have a later onset of development of secondary sex characteristics, yet the differences do not appear to be statistically significant.

Attempts to relate the incidence of prostate cancer to BPH have likewise shown conflicting results. One study of 838 patients with BPH and 802 age-matched controls studied for 10 years did not find any difference in the incidence of prostate cancer.[2] The second study, however, of 296 patients with BPH and 299 matched controls followed for 7 to 27 years found prostate cancer to be 3.7 times higher in the BPH group.[3]

Pathologically, 95% of all prostate cancers are adenocarcinoma. The degree of differentiation appears to correlate with metastatic spread and survival. A relatively objective grading system described by Gleason grades tumors on their ability to form glands, their tendency to uniformity, and the degree of invasiveness.[4] The histologic patterns are scored 1 to 5, and the sum of the scores of the major and

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minor (next most common) patterns is the Gleason sum. Sums of 2 or 3 correlate with a very low incidence of involvement of the lymph nodes while sums of 7, 8, 9, or 10 correlate highly with metastatic disease.[5]

Prostatic adenocarcinoma usually spreads directly to the seminal vesicles, the bladder base, or the membranous urethra. There is also frequent direct extension to the pelvic side walls. The primary lymphatic drainage of the prostate is to the hypogastric and obturator lymph nodes and from there along the iliac and periaortic chains. There also appears to be spread via the lymphatic and hematogeneous routes directly to the low lumbar vertebrae.

Distant metastases are primarily bone and lung with the liver being rarely involved. The bony lesions are unique in that they form an osteoblastic lesion which is quite characteristic on radiographs. This osteoblastic appearance is due to non-calcified osteoid being deposited within the interstices of normal bone giving the appearance of increased bone density.

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Clinical presentation of patients with prostate cancer is frequently due to metastatic disease. These symptoms include back pain, joint stiffness, and occasionally pathologic fractures. Local symptoms of prostatic carcinoma are primarily due to urethral outflow obstruction. Patients may also present with irritating bladder symptoms or urinary tract infection. Most patients with localized disease, however, are discovered incidentally on routine physical examination.

Though the rectal examination is the most frequent method of diagnosis of prostate cancer, approximately 10% of patients with prostatic cancer will have a normal feeling prostate by rectal examination. Should the clinician feel a suspicious nodule, then the next diagnostic step is a transrectal or transperineal needle biopsy of the prostate. Prophylactically, preceeding the biopsy, broad spectrum antibiotic coverage will reduce the hazard of post biopsy prostatitis to less than 1%.

The staging of prostate cancer is based on: 1) physical examination 2) acid phosphatase, 3) bone scan and, 4) pelvic lymphadenectomy. Any patient diagnosed with carcinoma of the prostate should have routine chest and pelvic x-rays, bone scan, and acid phosphatase. Lymphangiography or pelvic CT scanning may be used in the place of pelvic lymphadenectomy, but there is a significantly high number of false negatives (20-30%) such that the only true diagnosis is made by bilateral pelvic lymphadenectomies. False negatives are due to either: 1) the nodes being too small to be seen (microscopic disease), or 2) the nodes in question (obturator and hypogastric) not being filled during the lymphangiogram.

The technique of pelvic lymphadenectomy involves an extraperitoneal incision in which the lymphatic tissues from both pelvic sidewalls are excised. It should be stressed, however, that this is primarily a diagnostic and not therapeutic maneuver. Therefore, the extent of dissection should remain the external iliac vein to the hypogastric artery and along the obturator nerve. Hemostasis and lymphostasis are obtained by using metal surgical clips. Any attempts to go lateral to the iliac vessels will usually result in significant lymphedema of the genitalia and lower extremities, particularly if radiation therapy is later used.

Treatment of carcinoma of the prostate is dependent upon the stage. Stage A disease, which is disease found on routine transurethral resection, can be subdivided into A-1 and A-2. Typically, A-1 disease involves one to three chips, and A-2 disease involves greater than three chips. A-1 patients are treated by repeat transurethral resection or needle biopsy in 6 months, and if this is negative no therapy is required. A-2 disease, however, is considerably different in both its malignant potential and aggressiveness. The patients with A-2 or diffuse prostatic adenocarcinoma have an incidence of survival and incidence of positive nodal

metastases equal to or exceeding that of patients with Stage B disease. Patients with A-1 disease who have repeat transurethral resections 3 months after the initial diagnosis which is positive are reclassified to A-2 disease and treated appropriately.

Patients with Stage B disease (confined to the prostate on rectal exam, normal acid phosphatase, normal bone scan, negative pelvic lymphadenectomy) can be treated in one of three fashions. The longest historical series are patients treated by radical prostatectomy.[6] The surgical approach usually involves either transperineal or the retropubic approach. This operation involves total removal of the prostate, its capsule, the seminal vesicles, the ampulla of the vas deferens, and the bladder neck in continuity. There are proponents of both approaches, and there appears to be no clear cut advantage to either approach in the right hands. This procedure is associated with a virtual 100% incidence of impotence and 2-10% incidence of incontinence ranging from gross total incontinence to mild stress urinary incontinence.

The other treatments for carcinoma of the prostate both involve radiation therapy. The first type of radiation therapy is external beam radiation. External beam radiation therapy usually involves 5000 rads to the pelvic lymph nodes with a prostatic boost. Bagshaw reports 79% with 5-year survival, 58% with 10-year survival, 37% with 15-year survival for Stage B carcinoma.[7] The potential complications from this form of therapy, however, include radiation cystitis and proctitis in 10-20% of patients and impotence in 41% of patients. The efficacy of external beam radiation in the treatment of patients with prostate cancer is still under debate, since patients re-biopsied after their therapy continue to have positive biopsies. It has been noted, however, that many of these patients will have a negative biopsy later, and patients who have positive biopsies at 30 months or later after their radiation therapy will usually have progressive disease.[8]

The efficacy of external beam radiation in the treatment of patients with prostate cancer is still under debate, since patients . . . continue to have positive biopsies [after therapy].

The second form of radiation therapy which is somewhat newer is interstitial therapy. This therapy, known as brachytherapy, involves either ^{125}I or ^{98}Au. Most experience has been with the ^{125}I. ^{125}I in comparison to historic controls has shown it to be of equal efficacy at the 5-year level at Emory University, Memorial Sloan Kettering, and other centers. It will be the 10 and 15-year data which will prove the efficacy of this treatment. By use of this therapy, one can deliver up to 16- to 20,000 rads directly to the prostate. A very small percentage of this radiation will spill over to the rectum or bladder, making it more precise than external beam radiation. Due to the relatively short half-life of the ^{125}I and sharp energy fall off with distance, this therapy has been judged to be superior to the ^{98}Au, particularly in regards to post implantation complications. ^{125}I therapy is usually not suitable in patients who have had previous TURP, since these patients do not have adequate tissue into which to implant the seeds. If the patient has significant bladder outlet obstruction, however, a limited channel TURP should be performed since there is initial postoperative swelling due to reaction to the radiation. Typically, the prostate shrinks and approximately 10-15% of the patients treated with ^{125}I will later develop symptoms requiring transurethral resections or dilations of their bladder necks.

Treatment of Stage C disease (extracapsular, not involving the lymph nodes) is somewhat more controversial. These patients are either relegated to symptomatic relief of their outlet obstruction and hormonal therapy, or treated by more aggressive therapy such as radical prostatectomy or radiation. Radical prostatectomy in Boyce's series of patients with Stage C lesions produced less later morbidity such as hematuria and obstruction than expectant treatment, but in most series does not appear to have any significant impact upon the ultimate survival of the patient.

Obviously, radical surgery is not indicated in patients having extensive C disease, such as fixation to pelvic sidewalls. External beam radiation or brachytherapy may be used in Stage C patients, and these data are currently being evaluated. Bagshaw's data with external beam therapy would show approximately 36% ± 6% probability of survival at 10 years, 22% ± 7% probability of survival at 15 years.[9]

Patients with extracapsular extension and metastatic disease either in nodes or bones are treated conservatively. These patients may receive symptomatic therapy for bladder outlet obstruction either by transurethral resection or hormonal therapy. Considerable controversy exists as to when hormonal therapy may be given. Approximately 70% of the patients will respond to hormonal therapy for varying times but usually approximately 6 months. Some advocates propose giving hormonal therapy initially to reduce the tumor burden. The second group proposes delayed hormonal therapy based on the VA statistics that there is no significant impact on ultimate survival with delayed or immediate hormonal therapy. However, by delaying the hormonal therapy until the patient is symptomatic, there may be some impact on the quality of life. Hormonal therapy may be either estrogens, of which we favor 3 mg/day of diethylstilbestrol (DES). The method of action of this form of therapy is pituitary suppression of FSH and LH and subsequent decrease in testosterone production. The second form of therapy is orchiectomy which directly removes the testosterone. Patients responding to the hormonal therapy initially, but later failing may be further tried on other forms of hormonal therapy including high dose stilphosterol, surgical adrenalectomy or medical adrenalectomy with aminoglutethemide or pituitary ablation. There has been some success with all these methods though the results are not nearly as dramatic as with initial hormonal therapy.

Approximately 70% of the patients will respond to hormonal therapy for varying times but usually approximately 6 months.

Thirty per cent of patients will not respond even initially to hormonal therapy. This is partly due to the fact that tumors are not a homogenous aggregation of cells. In fact, it has been shown experimentally that tumors are composed of a heterogeneous population of cells expressing different cell characteristics including differences in metabolism, cell surface antigens, and malignant potential. Perhaps the reason the patient does not respond to hormonal therapy or the reason the disease later progresses after successful hormonal therapy is due to a population of hormonally insensitive cells. The treatment of patients with hormonally unresponsive tumors has shown modest success. Therapy using a combination chemotherapy of alkeran, vincristine, 5 FU, methotrexate, and prednisone has shown an approximate 36% overall response rate.[10] If cytoxan is substituted for the alkeran, there appears to be no enhanced survival, while if the cytoxan and alkeran are completely eliminated there appears to be a worsening of the response rate. With the above protocol, survivals have been extended from 26 weeks to 52 weeks average survival. Other therapy which are currently being evaluated includes the modified FAM protocol which is to begin a Phase I trial at Emory University. This protocol involves 5 FU, Adriamycin, and Mitomycin C. The patients are pre-dosed with methylprednisolone and receive monthly doses of 10 mg. Mitomycin C instead of the standard 20 mg. every other month of Mitomycin C. This protocol, in one trial, has shown an approximate 40% response rate.[11]

Chemotherapy with other agents which are cell cycle specific and agents which depend upon rapidly multiplying cells are not successful in patients with prostate carcinoma. This may be due to the fact that the tumors are typically relatively slow growing and therefore are relatively insensitive to the cycle specific therapy. It may be that the best therapy for metastatic prostatic cancer outside of hormonal therapy would be relatively non-toxic drugs given over a long period. This hypothesis remains to be proven.

As the average age of the adult population continues to expand with our enhanced medical care for the elderly, the incidence of prostate cancer should continue to climb. At present, the therapy is a multi-disciplinary approach based on the stage. No one therapy or combination of therapies has shown exclusive or significant benefit over other therapies, judged stage for stage. Further investigation into the methods of early diagnosis as well as the mechanisms of control of disease in combination with better therapeutic agents should have a significant impact upon the disease.

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president's letter



Toward Improvement of Infant Mortality

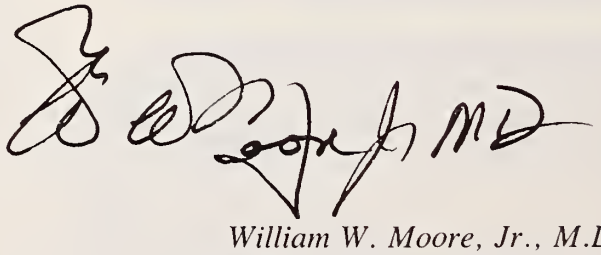
We have a serious medical and social problem: namely, a statewide infant mortality rate exceeded only by Washington, D.C., and our "thank God for" neighbors South Carolina and Mississippi. Dr. Luella Klein and her Maternal and Infant Health Committee have documented this in a report given to the Executive Committee at its August meeting.

There are three specific ways that we can attack the problem. The first two are remedial and essentially deal with two important aspects of financing indigent medical care which is where most of the problem exists. The Department of Medical Assistance is proposing in partnership with the Department of Human Resources and the Office of Planning and Budget a "medically" needy classification for pregnant patients and for infants and children that would increase the availability of prenatal, delivery, postnatal, and pediatric care. This deserves our active support especially in the face of probable reductions in the overall Medicaid Program which may run from 5 to 41 million dollars (1 to 11 percent).

Secondly, we should seek to enact funding for already passed legislation (Act 79-1234-HB 691), the "non-resident Health Care Fund." This would allow and provide for joint payment by the state and county of residence for medical services rendered in another county.

Finally and most importantly, we should work toward a program of at least "availability" of sex education at the middle school level. The relationship of infant mortality to the age of the mother is well established, and the major part of the problem concerns early teenage pregnancies.

Let your legislators know of your concern and wishes. Part of the solution is in their hands.



William W. Moore, Jr., M.D.

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PERSONALS

First District

Vergil Abreu, M.D., has been elected a Fellow in the American Society of Abdominal Surgeons.

Joseph Carruth, M.D., of Dublin, has been elected to Fellowship in the American College of Cardiology.

Third District

John S. Newton, M.D., an ophthalmologist and former President-elect of the Muscogee County Medical Society, is leaving Columbus to practice in Moultrie. He is a former Chairman of the Section of Ophthalmology of the Department of Surgery, The Medical Center. Dr. Newton helped and advised The Medical Center in the acquisition of Laser technology for eye patients in the Columbus community.

The Citation Award was presented to **Jack C. Hughston, M.D.,** at the 30th Annual Meeting of the American College of Sports Medicine, in Montreal, Quebec, Canada, in May, 1983, for his pioneering contributions to the development of sports medicine as a medical specialty in the United States. His application and promotion of innovative surgical techniques for the correction of sports injuries was instrumental in advancing the treatment of athletes and accelerating their return to competition. Beyond the operating room, Dr. Hughston has significantly advanced the profession of sports orthopedics as a founding member of the American Orthopedic Society for Sports Medicine, the National Athletic Trainers Association, and the Internal Society of the Knee as well as being a founder and editor of the *American Journal of Sports Medicine*.



Dr. Hughston

Fifth District

Atlanta physician, **Donald Bickers, M.D.,** received the Meritorious Service Award of the Georgia Rehabilitation Association at the Annual Conference held in August, in Savannah. Dr. Bickers received this award for his contributions to the Rehabilitation Agency in providing treatment to their clients for 30 years.

Peter J. Sones, M.D., has been named a Fellow in the American College of Radiology.

F. William Dowda, M.D., Atlanta, has been selected as the Secretary-Treasurer of AMA Education Research Foundation.

Cardiovascular/thoracic surgeon, **William D. Logan, Jr., M.D.,** was elected to serve on the Georgia Lung Association Board of Directors' Executive Committee for 1983-84.

Sixth District

T. J. Lin, M.D., has opened an OB/GYN practice at Coffee General Hospital in Douglas.

Tenth District

Forrest Doud, M.D., has opened a private practice in pediatrics in Conyers.

John A. Fountain, M.D., has begun practicing dermatology in Conyers.

J. Michael Petway, M.D., recently became associated with the Wells Clinic in Newnan.

MAG Members Appointed to the Composite State Board of Medical Examiners



Four new appointments and one reappointment were recently made to the Composite State Board of Medical Examiners. They included three MAG members from right to left, next to Governor Joe Frank Harris: Irving T. Stanley, MD, of Marietta (7th District); Donald L. Branyon, Jr., MD, Athens (10th District); and L. Newton Turk, III, MD, Atlanta (5th District). Renette Flowers, MD, of Decatur, a non MAG member, was also appointed and Joseph L. Vinci, DO, Statesboro, was reappointed. Governor Harris conducted the swearing in of these new members to the Composite State Board on August 11, 1983.

SOCIETIES

The **Muscogee County Medical Society** held a barbecue on September 22nd at the Green Island Country Club to welcome the new members and their spouses to the community. Special guests were members of the local legislative delegation.

In September, **John F. Kiser, CAE,** completed 20 years service as Executive Director of the **Medical Association of Atlanta,** and 30 years in organized medicine. Prior service was with the Medical Association of Georgia and the American Medical Association.

DEATHS

Herbert A. Hudgins, M.D.

Herbert A. Hudgins, M.D., 70, director of Health Services for the Gwinnett-Rockdale-Newton Health Services District, died August 16. Dr. Hudgins graduated from Emory University School of Medicine and the University of North Carolina School of Public Health. He also received training at Grady Memorial Hospital and did his residency at Steiner Cancer Clinic in Atlanta. He was retired Director of U. S. Public Health Services Regional Office in Atlanta.

Survivors include his wife, two daughters, three sons, five sisters, and ten grandchildren.

William Steve Worthy, M.D.

William Steve Worthy, M.D., of Carrollton, died August 8, at the age of 71. Dr. Worthy attended Emory University and graduated from the Medical College of Georgia. He was a founding member of the American College of Obstetrics and Gynecology, and a member of the Georgia State Obstetrical Society. He served as Chief of Staff at Tanner Memorial Hospital, chairman of the Board of Trustees of the West Georgia College Foundation and president of the Fourth District A & M Alumni Association. In 1970, Dr. Worthy received the Distinguished Alumnus Award and in 1973 was chosen the Carrollton Chamber of Commerce "Man of the Year."

Dr. Worthy is survived by his wife, two daughters, two sons, and ten grandchildren.

Committee Activities . . .

Highlights — Executive Committee Meeting, August 14, 1983

Impaired Physicians Committee (Policy Statement) — The June Executive Committee requested the Impaired Physicians Committee to submit a draft of a MAG policy statement regarding exactly what constitutes MAG advocacy of impaired physicians. After consultation with legal counsel and presentation at this meeting, the Executive Committee approved the Impaired Physicians Program policy statement regarding the circumstances in which MAG "advocacy" will be made available to impaired physicians.

Committee on Legislation (DHR Medical Nominating Commission) — The July Executive Committee directed the Committee on Legislation to research and report to the August meeting relative to the deletion in Georgia's new Constitution of the Medical Nominating Commission to the DHR Board. The Staff Attorney for Governor Harris was contacted regarding this matter. MAG was given to understand that Governor Harris would not object to legislation being introduced in 1984 to re-enact legislation to provide for a Medical Nominating Commission. The Executive Committee directed the Committee on Legislation to proceed to have such legislation introduced.

Membership Committee (Benefits Package) — The Committee submitted an additional membership benefits package to the Executive Committee for consideration. This package consisted of (1) members purchasing computer products from Select Systems, and (2) purchasing computer software designed for office management from MEDPAC. The Executive Committee accepted this as information and requested that it be studied by the Executive Committee members and brought back to the September meeting for discussion.

Membership Insurance (Disability Income Insurance) — In a memorandum from the Chairman of the MAG Membership Insurance Committee, the Executive Committee was requested to approve a disability income insurance program offered by the National Life Insurance Company of Vermont. Representatives from that company made a presentation on rate structure for MAG membership. The Executive Committee accepted this as information and requested that the material presented be mailed to Executive Committee members for study and discussed at the September meeting.

Physician/Lawyer Liaison Committee — This committee has scheduled a Medical-Legal Conference on October 29, 1983, from 10:00 AM to 4:00 PM at the Academy of Medicine (MAA), to discuss Patient/Physician Relationship vs. Client/Attorney Relationship, Legal Issues in the Medical Practice, Medical and Legal Ethics, and *Principles Governing Physician-Attorney Relationships*, Authorized and Unauthorized Release of Medical Records.

Maternal and Infant Health (M & I) Committee — The Chairman of this committee presented information regarding the infant mortality rate in Georgia. A committee of the Georgia legislature is holding hearings on the problem of infant deaths throughout Georgia. Since most infant deaths occur within the first day, week, and month of life, most of the problems deal with prenatal delivery and newborn care and with low birthweight infants. The M & I Committee requested direction from the Executive Committee as to how to address the issues associated with the fact that the Georgia infant mortality rate remains one of the poorest in the nation — 47th in rank. Several suggestions were made. After discussion the Executive Committee recognized the need to deal with the Georgia infant mortality rate on a high priority basis. It further authorized the Chairman of the M & I Committee to be in charge of a task force consisting of members of the M & I Committee, representatives of the OB/GYN, Pediatric, and Family Practice specialties, and the DHR to formulate plans for improvement in this particular area. This matter will be brought back to the September Executive Committee meeting for further discussion.

Risk Management Committee — The Chairman of the Risk Management Committee requested permission from the Executive Committee to use monies generated from Risk Management Seminars (Workshop #1) to develop an additional Risk Management Workshop to be presented in either 1-day or 2½-day seminars. It is anticipated that these seminars would accumulate seven or eight continuing medical education units and additional reductions in malpractice premiums. The Executive Committee approved the plan.

Professional Liability Insurance Committee — The Chairman of the MAG Professional Liability Insurance Committee, reported on the following issues: (1) Exposure of members signing contracts with third party vendors, i.e., DRGs, PPOs, HMOs or IPAs. Liability companies contacted by the committee will continue to accept applications from Georgia physicians on merit and not refuse coverage to those who signed contracts with Third Party Providers. Previous experience indicates this exposure will not materially affect professional liability in Georgia; (2) Georgia physicians not covered by professional liability insurance. The Committee reported that this does not appear to be a problem at this time. There is no statewide monitoring mechanism in existence. The Executive Committee took this matter under advisement, and on motion agreed that MAG proceed with a cooperative program with the Georgia Hospital Association to monitor this potential problem area.

MAG/MAA Intrav Travel Program — At the March Executive Committee meeting, the matter of the MAA Travel Program was discussed because of concern regarding the quality of the CME programs offered in some of the excursions. Contact was made with MAA regarding

this matter and as of this date, the matter has been resolved with MAG reviewing this educational program.

Medical College of Georgia President — Jesse L. Steinfeld, MD, past Surgeon General of the U.S. Public Health Service, was appointed President of the Medical College of Georgia.

Financial Report — The Executive Committee approved the Balance Sheet of Revenue and Expenses as submitted for the period ending July 31, 1983.

Prison Health Care Committee Appointment — The Executive Committee approved Douglas Skelton, MD, Decatur, as a member of the Prison Health Care Committee. Dr. Skelton has agreed to serve in this capacity.

Membership Outreach Program — The 1983 House of Delegates adopted a resolution that provided, "That MAG establish a program to stimulate county medical societies to educate physicians regarding MAG activities and the benefits of MAG membership and to cooperate with the societies in this endeavor. Further, that MAG provide a specific team of MAG staff to travel to those areas to aid in this undertaking." The Executive Director presented a plan to expedite this action of the House. The Executive Committee voted to underwrite and endorse this program.

Licensure of Radiologic Technicians — A report was made regarding a Consumer-Patient Radiation Health and Safety Act to be introduced to the 1984 Georgia General Assembly to govern the education and certification of persons who apply ionized radiation to human beings in Georgia. This includes persons who take x-rays in doctors offices as well as radiology technologists in hospitals. In August, 1981, Public Law 97-35, Consumers Patient Radiation Health and Safety Act, was "tacked on" to another bill and passed by the federal government. This law basically requires states to establish their own law, within 3 years (by August, 1984), or be subject to federal law. A task force was organized by the Radiological Health Section of the DHR to draft legislation for Georgia. This task force is composed primarily of persons directly involved in radiology. Physicians who do limited x-ray procedures in their offices were really not represented; but one of the members of this task force felt that the draft that was revised at the August 11th meeting of the task force would be much better for Georgia physicians and patients than the federal law. The Executive Committee directed the Committee on Legislation to investigate this matter, both state and federal, and report back to the September Executive Committee meeting.

FDA Forum on Consumer Advertising of Prescription Drugs — MAG's Consultant for Drugs attended a Regional Hearing of the Federal Drug Administration regarding advertisement of prescription drugs directly to consumers and reported that everyone at that meeting had opposed direct advertisement of prescription drugs. This matter was received as information.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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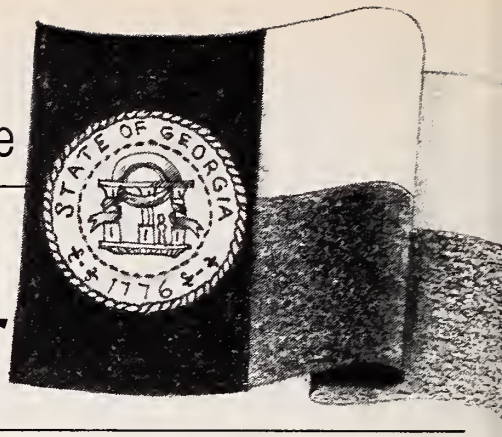
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Dr. Crawford W. Long

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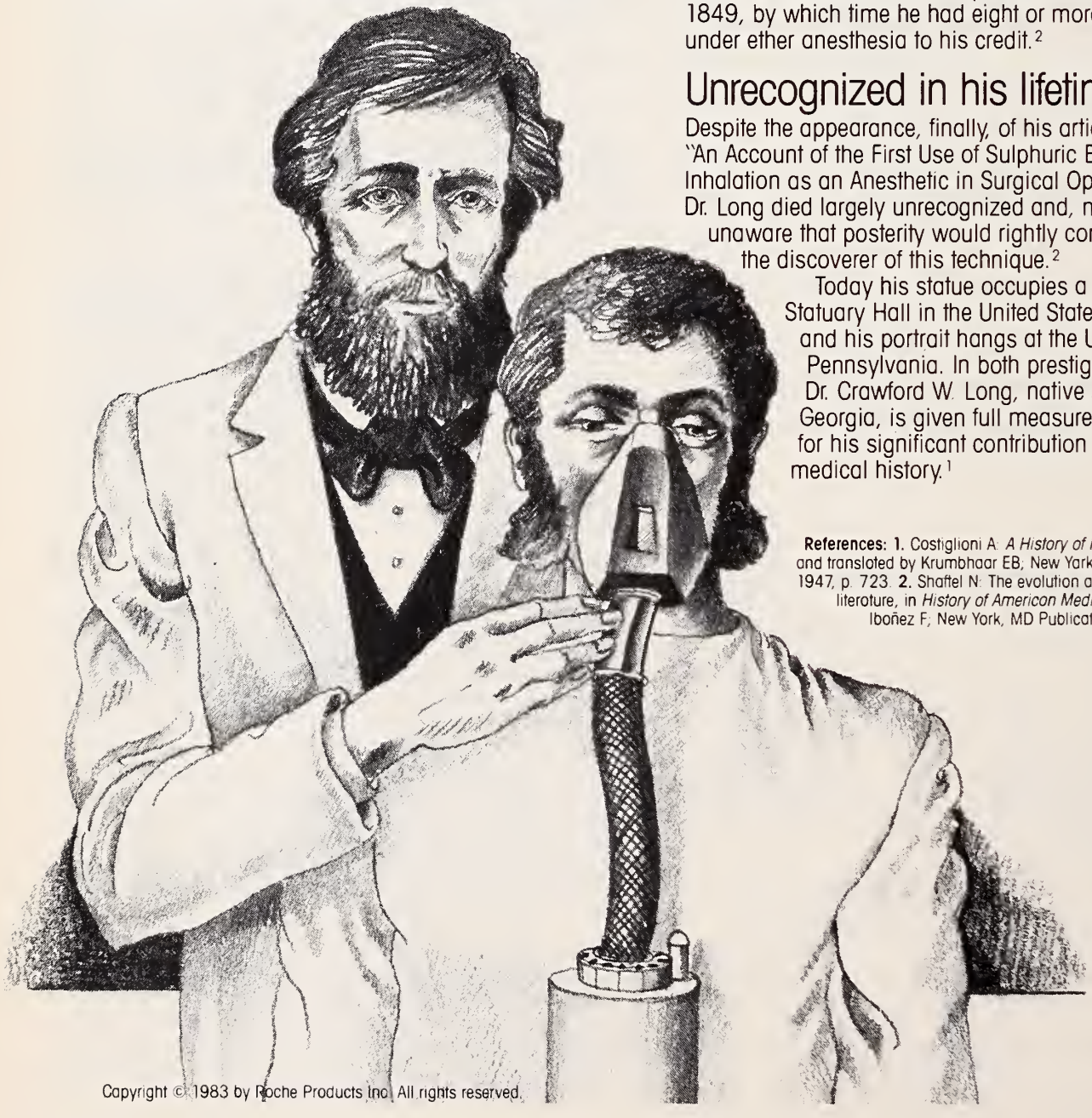
A simple country practitioner in Jefferson, Georgia, Dr. Long had little surgical experience when, on March 30, 1842, he experimented with the use of sulfuric ether as an anesthetic in the surgical removal of a small septic tumor from the neck of a patient. The patient, James Venable, reported feeling no pain during the incision and removal proceedings, and soon recovered.[1,2]

Pleased by the results of surgery under anesthesia, Dr. Long continued to use ether in surgery and obstetrics. Recognition for his accomplishment was limited, however, because he did not publish his discovery until 1849, by which time he had eight or more operations under ether anesthesia to his credit.[2]

Unrecognized in his lifetime

Despite the appearance, finally, of his article titled "An Account of the First Use of Sulphuric Ether by Inhalation as an Anesthetic in Surgical Operations," Dr. Long died largely unrecognized and, most assuredly, unaware that posterity would rightly consider him the discoverer of this technique.[2]

Today his statue occupies a place in Statuary Hall in the United States Capitol, and his portrait hangs at the University of Pennsylvania. In both prestigious locations, Dr. Crawford W. Long, native son of Georgia, is given full measure of respect for his significant contribution to medical history.[1]



References: 1. Castiglioni A: *A History of Medicine*, edited and translated by Krumbhaar EB; New York, Alfred A. Knopf, 1947, p. 723. **2.** Shaftel N: The evolution of American medical literature, in *History of American Medicine*, edited by Morti-Iboñez F; New York, MD Publications, 1959, p. 107.

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- ☐ Early insomnia—91%
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 Late insomnia—89%
- ☐ Gastrointestinal upset—73%

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Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychophormocology in the Proctice of Medicine,* edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Feighner JP *et ol: Psychopharmocology 61:* 217-229, Mar 1979. **3.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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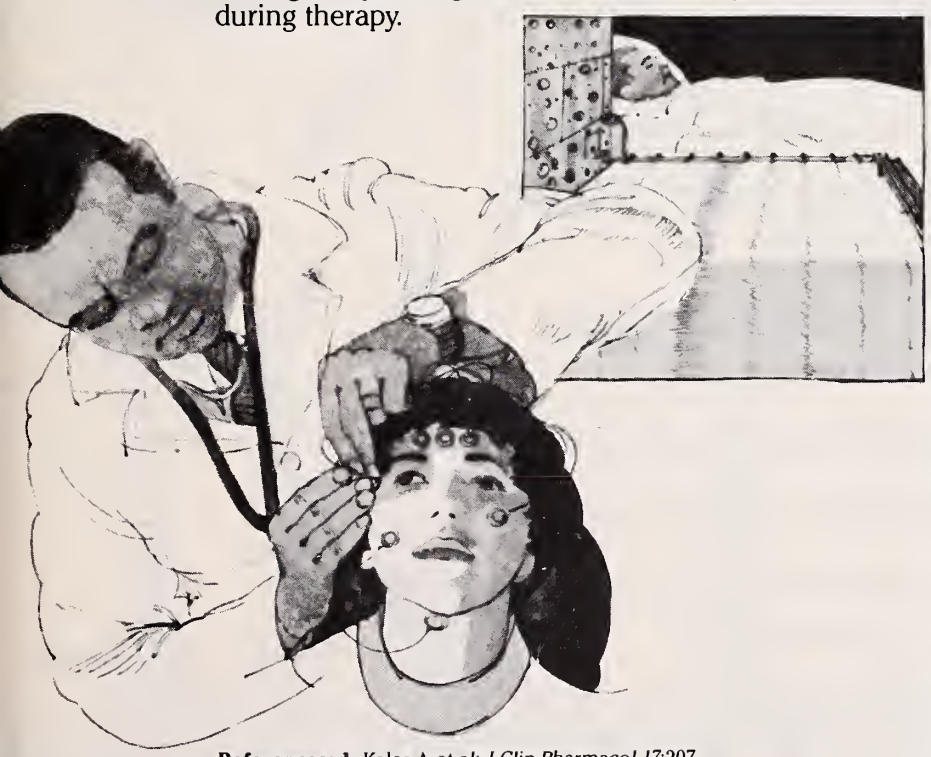
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- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

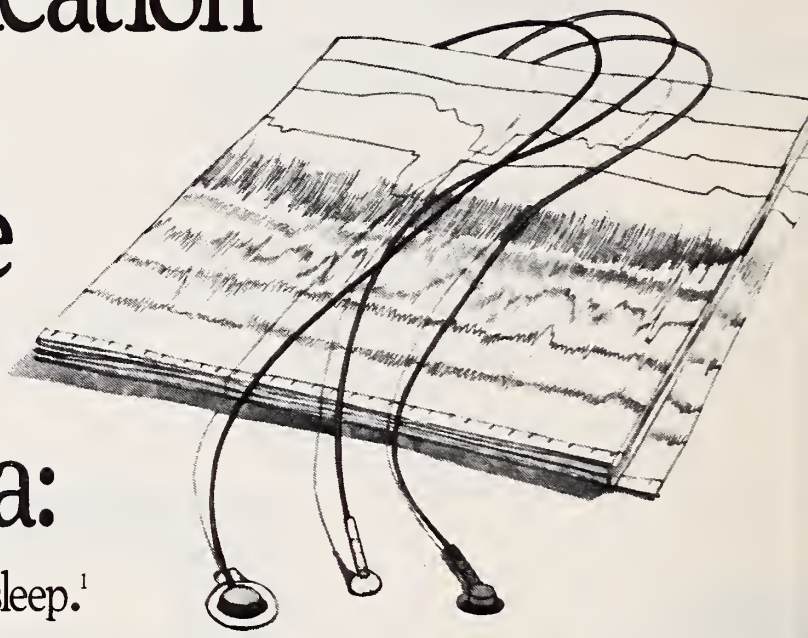
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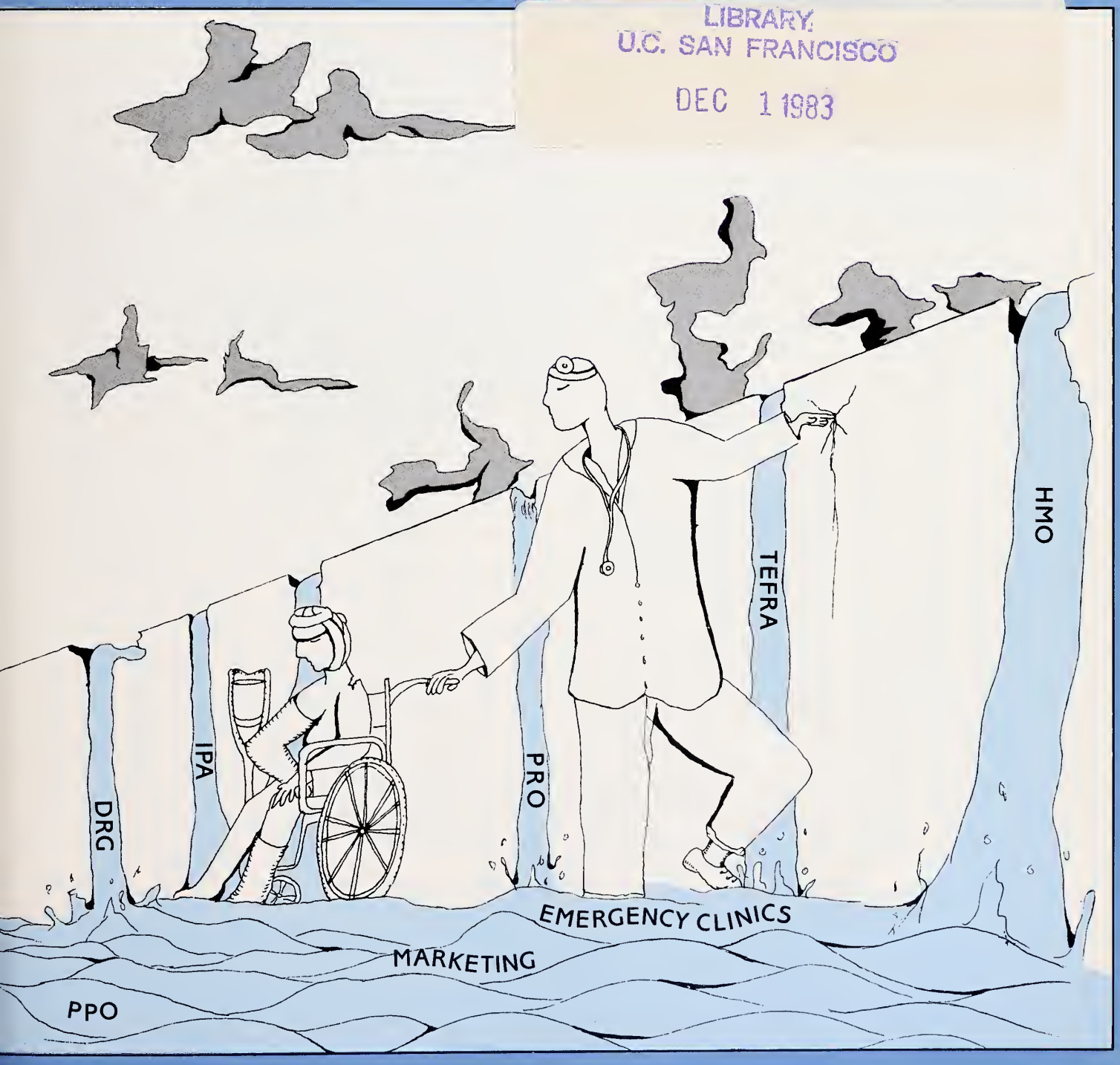
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VOLUME 72, NUMBER 11

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Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

The private practice of medicine has been flooded by change in recent years. The Second Annual MAG Leadership Conference is designed to teach physicians how to manage the impact that the new concepts, new arrangements, new structures, etc. in medical care delivery are certain to bring.

The cover design is by Richard C. Hagerty, M.D., a 4th-year resident in plastic surgery at Grady Memorial Hospital in Atlanta. Dr. Hagerty's artwork is available at Fay Gold Gallery, Atlanta.

Incidental Intelligence . . .

MAG Initiates Physician Recruitment Program

A persistent maldistribution of physician manpower continues to linger well into the 1980s. Despite the rapid growth of new medical schools in the 1960s and 1970s, many areas throughout the United States still have a serious physician shortage. Nowhere is this problem more evident than in the rural regions of many states where a lack of doctors has actually become the norm.

Most of the 35 counties comprising the Appalachian region of Georgia are typical doctor-shortage areas. For many years, this part of north Georgia has been a low priority in health manpower planning efforts. Some important strides have been made to solve this problem. Organized attempts to increase the number of physicians have been made but have not made significant impacts on the physician distribution in that region. This situation is now on the threshold of positive change.

The Medical Association of Georgia, in cooperation with the Georgia Department of Human Resources, has initiated a new physician recruitment effort. With funding from the Appalachian Regional Commission, the project is geared to provide technical and organizational support to those Appalachian communities that wish to secure the services of a primary care physician. This joint MAG-DHR project is based on the assumption that communities — cities and counties — participating in the program have a long-term commitment not only to recruit but also to maintain a physician work force over time.

One innovative part of this program is the idea that practicing physicians are probably the best recruiters. Very little is known about the job satisfaction factors of physicians in rural practice and their intent to stay in practice. This project will attempt to uncover those factors that may "cause" a physician to remain in north Georgia. After these factors are known, they will become the major links upon which physician-community matches will be made. In other words, the retention of physicians will, in itself, be a major recruitment strategy.

It will be some time before the full benefits of increased medical manpower can be measured in the northern part of Georgia. Yet, the immediate effects of this new program will be: greater coordination among agencies in the physician recruitment business, participation of community leaders and "retained" physicians in grass-roots planning, and the establishment of a step-by-step recruitment-retention methodology that will be applicable to other areas.

DRG Rules Make Debut

Rules to put in place a new payment system considered to be the biggest change in the history of Medicare were published September 1 — just one month before the first hospitals entered the new system.

And on September 19, AMA Executive Vice President James H. Sammons, MD, told hundreds of physicians from across the nation that "the diagnosis related groups, or DRGs, mark a historically momentous change in the way government pays its share of medical and health care cost." Dr. Sammons was speaking at the AMA conference on Peer Review Organizations and the Prospective Payment System, heavily attended by state medical and specialty society executives.

Much of the DRG plan, which bases Medicare payments to hospitals on predetermined rates for each of 468 illness or injury categories, has been known to hospitals since it was created by Congress as part of the Social Security Amendments enacted last fall.

Only since the publication of the regulations in the September 1 *Federal Register,* however, have hospitals been able to calculate exactly how much they will be paid for each of the diagnosis related groups (DRGs) and compare it to their current reimbursement for the procedure.

Medicare officials said they do not expect the changes to have any immediate impact on beneficiaries and stressed their belief that hospitals can improve efficiency without downgrading quality of care.

Payments to physicians are not directly affected by the new pricing mechanism. However, hospitals are expected to change their behavior in ways that will have a substantial impact on physicians, and Congress has asked for a study of the feasibility of including some physician payments in the plan in later years.

Last year, about two-thirds of the $50.9 billion Medicare paid for care of its 26 million elderly and 3 million disabled beneficiaries went to hospitals. Previously-enacted changes in Medicare already were expected to keep payments to hospitals about $1.5 billion below what they would have been otherwise, and the new DRG plan, just as Congress ordered, has been deliberately set to save the same amount as would have occurred under the earlier changes.

Federal officials said they can't estimate how much the program ultimately may save, but they think it could be "billions" if payments are "ratcheted down" hard enough. Without further changes, however, the Medicare hospital trust fund is still expected to be bankrupt by 1990.

About 1,500 of the nation's 7,000 hospitals came under the DRGs on October 1. Another 4,000 will be phased in as they start their new accounting years. The remainder are exempt for the time being.

Developed at Yale University, the DRG system is based on 468 illness categories that take account of factors such as age and sex. The categories are weighted according to the cost involved in treating the condition. For example, payment for a coronary bypass with a cardiac catherization (DRG 106) would be 10 times the payment for a cataract operation (DRG 39) weighted at 0.510. The

Yale system used 467 DRG categories but DRG 468 has been added to the federal plan to cover situations when two unrelated procedures are performed.

The actual payment to the hospital is derived by multiplying the weight of the DRG times a base payment calculated by Medicare officials. Hospitals will be paid at the predetermined rate no matter what their costs were, although there are some adjustments for unusually high cost or lengthy cases.

If the hospital's costs exceed the payment rate, it must absorb the loss. If costs are below the payment, the hospital can make a profit.

Initially, the actual payment to the hospital will vary by region and by hospital since the base rate is calculated from a blend of the hospital's historical costs and adjusted average rated for all hospitals in the region and a national rate. Both an urban and a rural rate have been calculated for each of nine regions and for the nation as a whole.

Base rates will continue to be blended — with regional and hospital-specific rates making up a decreasing proportion of the blend — for 3 years. In the fourth year, there will be only the two national rates.

The newly just-published regional rates vary from about $2,142 for a rural hospital in Louisiana or Texas to about $3,021 for an urban institution in Illinois or Ohio. National base rates have been set at $2,837 for urban hospitals and $2,264 for rural facilities.

Several adjustments have been made in the hospital-specific rates, including one involving payments to certain types of personnel — such as lab technicians and nurse anesthetists — whose services to the hospital in the past may have been billed through a physician rather than through the hospital.

Known as "unbundling," this practice, which Medicare officials say has been spreading, will no longer be permitted. As of October 1, any hospital services provided by non-physicians will be paid only through the hospital. This will apply whether or not the hospital involved is under the DRG program, although an exception will be made for a limited time for nurse anesthetists and for certain facilities such as the Mayo Clinic where unbundling has been a long-standing practice.

The new payment system does not apply to outpatient services, capital expenditures or medical education, all of which for the time being will still be reimbursed on a cost-related basis. Acquistion of kidneys for transplantation will be reimbursed at cost, but only at certain regional transplant centers.

About 20% of all hospitals will be excluded from the DRG plan either because they are covered through one of four state cost control programs (New Jersey, New York, Maryland, or Massachusetts) which have received Medicare waivers or because they are a type of facility exempted from the law. The latter include psychiatric and rehabilitation facilities and sole community hospitals in remote areas.

The system also provides for some patients where the cost or length of hospital stay greatly exceed what would be expected for the average case in the DRG.

Called "outliers," these are defined as cases where the length of stay exceeds the mean by the lesser of 20 days or 1.94 standard deviations, or where the costs exceed the DRG payment by 1.5 times the DRG payment or $12,000, whichever is greater. Hospitals will recover about 60% of their costs in excess of the DRG payment for these cases. Nationally, the total proportion of outlier payments will be limited to 6% of total DRG payments for all hospitals.

Extending DRGs to M.D.'s?

Despite reports to the contrary, Medicare officials say they haven't reached any conclusions about extending DRGs to physicians.

That was the message program officials brought to an AMA-sponsored meeting in Washington. But they also warned that if physician DRGs are recommended, payments to the physician might be made as part of a lump sum to the hospital. On the other hand, the payment might be made to the physician who would then pay the hospital, they said.

Despite the seemingly flip-flop attitude at HHS, what is clear is that the Congress has directed the Department to study and advise the Congress as to the "advisability and feasibility" of extending DRGs to physicians' services to hospitalized patients. Some critics charge that the Department has already made up its mind on the issue — that the only question is how, not whether, to extend DRGs to physicians.

HCFA officials at the AMA-sponsored meeting took issue with that view, saying they have not prejudged the data they are just beginning to collect. The question, HCFA Administrator Carolyne Davis, PhD, told the group, "is not one of feasibility but of advisability."

A physician DRG "is feasible, given a period of time for us to collect the data," Davis said. "What we don't know yet is whether it's advisable, and I know of no way to make that determination except to step back and examine all aspects of physician reimbursement."

In developing a recommendation regarding physician DRGs, Davis said she will be guided in part by an *ad hoc* group of physicians whom she personally selected and which include several AMA delegates and alternate delegates.

HHS has also set up several studies to help decide whether physicians should be included in DRGs. One by Brandeis University Health Policy Center will help determine whether DRGs are "sensible given the way physicians practice," HCFA official Alan Dobson reported.

Another by a Northern Virginia consulting firm, Mandex, Inc., will look at data from New Jersey and South Carolina to see what happens when Part A and Part B data are merged and to determine how many of the physician changes prior to and following hospitalization should be included in the DRG. A third study by the Urban Institute is aimed at the development of a method of determining relative values of procedures in a DRG-type system. A fourth by the Center for Health Economics Research will use North Carolina and New Jersey data to focus on how to package physician services in a DRG.

The latter will be addressing one of the critical questions associated with including physicians in DRGs — who do you pay? As HCFA's Dobson puts it, there are

three possibilities: paying hospitals a lump sum to be allocated among the hospital and physicians; paying the physicians a lump sum to be shared with the hospital; or paying "as we do now," with physicians reimbursed under Part B and hospitals under Part B.

One thing that has already been pretty much decided, according to Dobson, is that there will be a lump sum payment. "We're not too inclined to pay separately for each physician," he said.

Sen. David Durenberger (R-MN) also thinks there should be one lump sum payment — preferably to the physician. Durenberger, who chairs the Senate Finance health subcommittee, said that if "an individual physician or a physician organization were willing to accept the entire payment and contract with the hospital for institutional services, then to me that's a better way to go. . . If physicians are not willing to accept that responsibility, of course we as payers are going to choose to pay the hospital."

New ID System for Tracking AIDS

Responding to physician pressure to preserve patient confidentiality, the Centers for Disease Control has devised a new identification and reporting system for AIDS cases.

Physicians in Washington, DC, New York and several other cities recently stopped reporting names and personal identifiers to the CDC. Instead, city health officials reported only initials, sex and date of birth of patients. Additionally, physicians only partially completed the four-page case reports.

So the CDC has decided it no longer will require names of patients.

Instead, each case report will be identified using a special code. The detailed case reports have been scaled down to one page, requiring information only directly relevant to the AIDS diagnosis.

The new SOUNDEX code on each case report will identify patients by the first letter of the patient's last name and three numbers (each representing a letter in the name). Some letters of the alphabet are represented by the same number; some letters are not represented at all. Thus, it is impossible to reconstruct a name knowing only the SOUNDEX code, CDC officials say. For example, the code "H 452" could be used for the name Holmes. But it could just as well represent the name Hollings.

The revised case report will no longer require that physicians describe non-specific symptoms or signs of AIDS such as fever, weight loss, or enlarged lymph nodes. Nor will physicians be asked to pinpoint the sites of lesions in Kaposi's sarcoma. Additionally, questions used to identify a specific method of diagnosis have been abandoned. For example, the CDC used to accept a diagnosis of pneumocystis pneumonia only when confirmed by biopsy; now, although the physician is instructed that biopsies are the only way to accurately identify the disease, he or she will no longer be asked to identify the method of diagnosis.

Neither system requires that physicians submit patient Social Security numbers, specific sexual practices, number of sex partners, or other information, the CDC stresses.

The new code could jeopardize long-term follow-up, CDC officials fear. Old and new patient information must be linked; thus, all new documents or lab specimens submitted to CDC must be accurately identified before coding. The CDC expects to spend more time on the telephone with state and local health officials who reported the cases.

Under the system, the records of AIDS patients are locked in CDC offices. Confidential information is also legally safeguarded under the Freedom of Information Act and Privacy Act. Neither the FBI nor CIA have access to this information. However, a CDC notice in the Federal Register says that "records may be disclosed to health departments and other public health or cooperative medical authorities in connection with program evaluations and related collaborative efforts to deal more effectively with diseases."

Confidentiality is an issue with any disease, of course. But in AIDS research, investigators must inquire about intimate details of personal life. In many states, homosexuals can't serve in the Armed Forces, teach children, or raise their offspring. In nearly half the country homosexuality is illegal.

"In investigating this disease, we've needed to examine and understand gay life styles. We've had to probe. Every disease raises the problem of confidentiality. But this disease raises it much more," said Assistant Secretary of Health and Human Services Edward N. Brandt, Jr., MD, at a recent meeting of state and local health officials in Washington, D.C.

Members of the gay community charge that the CDC has distributed names of AIDS patients on three separate occasions.

The CDC defends each instance, saying that it was essential to AIDS research. Two occasions involved scientific studies: the New York Blood Center study showed that, despite suspicions, AIDS was not linked to the hepatitis B vaccine and the Los Angeles Health Department study first identified the connection between sexual contact and AIDS. The third occasion — in which names were released to major city health departments — was necessary to identify any duplication of AIDS cases, says the CDC.

MEDICAL MEETING CALENDAR

NOVEMBER

17-20—*Sea Island:* **Georgia State Obstetrical-Gynecological Society Annual Meeting.** Category 1 credit. Contact Chester C. Lane, Exec. Secy., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3540.

18-20—*Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact Stephen Davis, Dir. of Ed., MAG, 938 Peachtree St. NE, Atlanta 30309. PH:404/876-7535, or 800/282-0224 (toll free in GA).

20—*Atlanta:* **4th Symposium on Health Care in Correctional Institutions.** Contact Dorothy Parker, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535, or 800/282-0224 (toll free in GA).

30-Dec. 4—*Atlanta:* **Eighth Southeastern Conference on Alcohol and Drug Abuse.** Contact Barbara Turner, Charter Medical Corp., Addictive Disease Div., 5780 Peachtree-Dunwoody Rd., Ste. 170, Atlanta 30342. PH:404/257-9333.

DECEMBER

2-3—*Atlanta:* **MAG Risk Management Seminar.** Cosponsored by St. Joseph's Hospital. Category 1 credit. Contact Wayne Oliver, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in GA).

2-4—*Atlanta:* **ECG Interpretation, Arrhythmia Management, Cardiac Rehabilitation and the Role of the Multipurpose Computer in the Primary Care Practice Setting.** AMA Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr. E., Englewood, CO 80112. PH:800/525-8651.

3—*Macon:* **Colo-rectal Cancer: Essentials for Primary Care Physicians.** Category 1 and AAFP prescribed credits. Contact Milford B. Hatcher, MD, Box 139, Mercer Univ. Sch. of Med., 1550 College St., Macon 31207. PH:912/743-2383.

3-4—*Atlanta:* **Regional Anesthesia: Surgery, Obstetrics, & Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

8-9 — *Atlanta:* **Promoting Health Through Nutrition: Partnerships-Ventures** (cosponsored by Office of Nutrition, Division of Public Health). Contact: Delores Kearny, R.D., M.Ph., Office of Nutrition, Ste. 1266, East Tower, 47 Trinity Ave., SW, Atlanta 30334. PH: 404/656-4826.

9-11—*Atlanta:* **From Head to Toes: A Practical Approach to Orthopaedics for Primary Care Physicians.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9—*Atlanta:* **Pediatric Asthma Update.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

10—*Atlanta:* **MAG Conference on Medical and Legal Issues.** Contact Mr. Wayne Oliver, MAG, 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in GA).

JANUARY 1984

13-14—*Atlanta:* **MAG Leadership Conference.** Contact James Moffett, Exec. Dir., 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 800/282-0224 (toll free in GA).

FEBRUARY

1-4—*Montego Bay, Jamaica:* **The Sixth Annual Pediatric Postgraduate Course.** Sponsored by the Scottish Rite Children's Hospital. Category 1 and AAFP prescribed credits. Contact Judson Hawk, Jr., M.D., Dir. of Ped. Ed., Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

9-14—*Atlanta:* **American Academy of Orthopaedic Surgeons 51st Annual Meeting.** Contact AAOS, 444 N. Michigan Ave., 15th Floor, Chicago, IL 60611. PH:312/822-0970.

18-25—*Park City, Utah:* **2nd Annual Winter Urology Seminar.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

20-25—*Augusta:* **19th Annual Family Practice Symposium.** Category 1 credit. Contact Division of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-Mar. 2—*Paradise Island, Nassau, Bahamas:* **Problems of Chronic Pain.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

APRIL

4-6—*Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

9-12—*Atlanta:* **Pediatric Infectious Diseases.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

12-14—*Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

14-15—*Atlanta:* **The Cardiac Patient: Management for Cardiopulmonary Bypass.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

27-29—*Atlanta:* **Advanced Cardiovascular Diagnostic, Therapeutic, Rehabilitation, and Patient Follow-Up Methods.** AMA Category 1 and AAFP prescribed credits. Contact International Med. Ed. Corp., 64 Inverness Dr., E., Englewood, CO 80112. PH:800/525-8651.

30-May 5—*Augusta:* **19th Annual Family Practice Symposium.** Category 1 credit. Contact Division of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

MAY

11-12—*Atlanta:* **3rd Annual Update of the Diagnosis and Treatment of Lupus Erythematosus.** Category 1 credit. Contact Stephen Balch, M.D., Dir., Jacquelyn McClure Lupus Treatment Ctr., 3200 Howell Mill Rd., NW, Atlanta 30324. PH:404/351-0351.

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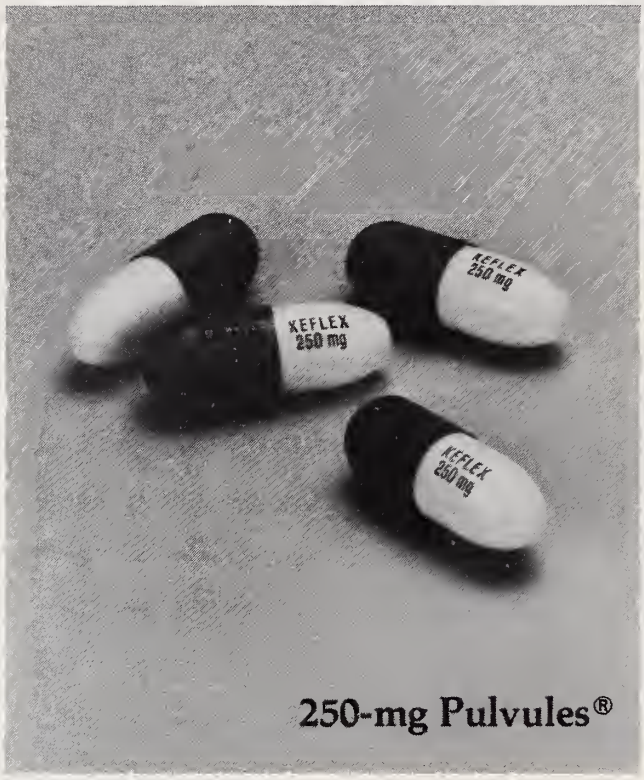
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JOURNAL
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MAG Leadership Conference:
The Private Practice of Medicine — Flooded by Change

JAMES M. MOFFETT, *Atlanta**

THE DELIVERY of medical care is changing at a rapid pace; so rapid, in fact, that before one innovation can be fully understood, we are confronted with yet another and another in what seems to be a flood of acronyms, each threatening, in one way or another, to dilute physician control of the practice of medicine. To help the physician better understand the changes now taking place, as well as those just beyond the horizon, MAG will hold its Second Annual Leadership Conference on January 13-14, 1984, at the new Waverly Hotel in Atlanta.

The unofficial theme of the conference is survival during an era of fast and unrelenting change — change that threatens to commercialize the practice of medicine; change that will promote contract practice to a new high; change that will usher in new and different reimbursement schemes, thus placing the traditional relationship between the physician and his patients in considerable jeopardy; and change that supports price competition in a way unfamiliar to most physicians.

To understand the changes that have recently occurred, as well as those likely to, MAG has lined up a group of experts to constitute the faculty for the Leadership Conference. Their job is to help put you in a better position to manage the impact that the new concepts, new arrangements, new structures, and new alliances are certain to bring.

Highlighting the Friday (1/13/84) session will be Paul M. Ellwood, Jr., M.D., President of InterStudy, a medical think tank located in Excelsior, Minnesota. Dr. Ellwood will discuss InterStudy's recently devised MeSH, a medical staff-hospital joint venture that is designed to permit hospitals and their medical staff to jointly and equitably participate in a variety of new price-sensitive payment arrangements. The MeSH (Medical Staff-Hospital) organization establishes a corporate relationship between the hospital and its medical staff aimed at enhancing their competitive position with payers whose prospective rates of payment are based on a combination of volume and unit price of health services. The MeSH concept seeks to simultaneously deal with the evolving, differing, and complex clinical and economic goals of physicians, hospitals, patients, and third parties.

Also featured on the Friday program will be John W. Clark, M.D., a nationally recognized authority on physician-hospital contracts and compensation plans. Dr. Clark is Medical Director at Research Medical Center in Kansas City, Missouri. His presentation will include a discussion on the corporate or hospital practice of medicine and ambulatory care program physicians. In addition, he will talk on effective physician compensation plans in detail.

Rounding out the line-up of Friday speakers will be Paul L. Grimaldi, Ph.D., former Director for Health Economics Research Services of the New Jersey Hospital Association. Dr. Grimaldi, regarded as one of the nation's foremost authorities on diagnostic related grouping (DRG) of inpatient hospital services, is currently with the national consulting firm of Coopers and Lybrand in New York City. Dr. Grimaldi will talk on DRGs, present and prospective.

In the afternoon, there will be workshops on the Survival of Solo and Small Group Practice, con-

* Mr. Moffett is the Executive Director of the Medical Association of Georgia.

Survival in the Competitive Medical Marketplace

Friday, January 13, 1984

9:00 AM OPENING REMARKS
William W. Moore, Jr., M.D.
President
Medical Association of Georgia
Moderator

9:15 AM DO SOLO OR SMALL GROUP PRACTICES HAVE A CHANCE?
Paul M. Ellwood, Jr., M.D., President, InterStudy
Excelsior, Minnesota

QUESTIONS AND ANSWER/DISCUSSION

10:30 AM Break

10:45 AM CONTRACTS AND COMPENSATION
John W. Clarke, M.D.
Medical Director
Research Medical Center
Kansas City, Missouri

QUESTIONS AND ANSWER/DISCUSSION

12:00 Noon Lunch

1:30 PM DIAGNOSIS RELATED GROUPS — PRESENT AND PROSPECTIVE
Paul L. Grimaldi, Ph.D.,
Consultant, Coopers & Lybrand
New York, N. Y.

2:30 PM to 5:00 PM WORKSHOPS ON:
1—Survival of Solo & Small Group Practice
Paul M. Ellwood, M.D.
2—Contracts and Compensation
John W. Clarke, M.D.
3—Diagnosis Related Groups
Paul L. Grimaldi, Ph.D.

(Entire group will be divided by three and rotated through each workshop.)

5:00 PM Recess

6:00 PM MAG Hosted Reception

Saturday, January 14, 1984

9:00 AM THE HOSPITAL-PHYSICIAN DYNAMIC IN THE DECADE OF BELT TIGHTENING
Thomas F. Frist, Jr., M.D.
Chief Executive Officer
Hospital Corporation of America
Nashville, Tennessee

9:30 AM Break

9:45 AM HOSPITAL CREDENTIALING
Hugh P. Greeley, President
Greeley Associates, Ltd.
Salem, Wisconsin

12:00 Noon Lunch

ducted by Paul Ellwood; Contracts and Compensation, conducted by John Clarke; and DRGs, conducted by Paul Grimaldi. Those attending the Conference will be divided into three groups and rotated through each of the workshops.

On Friday evening, MAG will host a cocktail reception at the Waverly. All of the program speakers are being strongly encouraged to attend in the belief that casual dialogue between the speakers and program attendees is an important part of the overall program.

The Saturday (1/14/84) morning session will begin with Thomas S. Frist, Jr., M.D. Dr. Frist is the Chief Executive Officer of the Hospital Corporation of America. His talk is entitled "The Hospital-Physician Dynamic in the Decade of Belt Tightening." Dr. Frist is in a unique position to see the hospital as an entrepreneur and will discuss the relationships between hospitals and physicians that are most likely to evolve out of the revolutionary changes now taking place in medical care delivery.

The remainder of the Saturday morning program will be given to the all-important subject of hospital credentialing and delineation of clinical privileges. The speaker will be Hugh Greeley, a nationally prominent consultant and confidant of last year's Leadership Conference headliner, William Fifer, M.D.

Throughout the 2-day program, there will be ample time for questions and answers. CME credits toward the Physician Recognition Award of the American Medical Association will be awarded on an hour-for-hour basis.

Training Future Physicians for the Competitive Medical Marketplace

On Saturday afternoon, there will be a special presentation on "Training Future Physicians for the Competitive Medical Marketplace."

This special feature will begin immediately following lunch and will conclude at approximately 5:00 PM. It will examine the projected physician oversupply and how that oversupply may affect (1) future choices of specialty and practice locations in Georgia; (2) certification of allied health personnel and limited licensed practitioners; (3) funding by the state for medical education; and, (4) medical schools in Georgia.

Training Future Physicians for the Competitive Medical Marketplace

Saturday, January 14

1:00-1:10 WELCOME AND INTRODUCTION
William W. Moore, Jr., M.D.

1:10-1:40 THE COMING ABUNDANCE OF PHYSICIANS — THE NATIONAL OUTLOOK
Paul M. Schwab, Associate Administrator for Policy Coordination, U.S. Health Resources and Services Administration

1:40-1:55 HEALTH PROFESSIONALS IN THE SOUTH — TRENDS FOR THE FUTURE
Harold L. McPheeters, M.D., Director of Health Programs, Southern Regional Education Board

1:55-2:10 QUESTIONS/DISCUSSION

2:10-2:30 BREAK

2:30-2:50 PHYSICIAN SURPLUS AND THE CHANGING MEDICAL MARKETPLACE: THE CHALLENGE TO MEDICAL SCHOOLS
Donald O. Nutter, M.D., Executive Associate Dean, Emory University School of Medicine

2:50-3:10 MEDICAL SCHOOL CURRICULUM AND EDUCATING FUTURE PHYSICIANS ON COST CONTAINMENT
Terrence T. Kuske, M.D., Associate Dean for Curriculum Medical College of Georgia School of Medicine

3:10-3:30 THE MOREHOUSE PERSPECTIVE ON PHYSICIAN MANPOWER NEEDS IN GEORGIA
Louis W. Sullivan, M.D., President and Dean, Morehouse School of Medicine

3:30-3:50 MALDISTRIBUTION OF PHYSICIANS AND FUTURE EDUCATIONAL APPROACHES TO THE PROBLEM
William P. Bristol, M.D., Dean, Mercer University School of Medicine

3:50-4:15 DISCUSSION

4:15-4:30 CONCLUSION: WHAT CAN WE DO ABOUT THE FUTURE COMPETITIVE MARKETPLACE?
Charles D. Hollis, Jr., M.D., Immediate Past President, Medical Association of Georgia

Faculty



William W. Moore, Jr., M.D. — In his inaugural address as President of the Medical Association of Georgia, Dr. Moore expressed concern about the issues involving competition and the need to identify the various forces which impact upon Georgia physicians and their patients. As a result of his concern, Dr. Moore has been a driving force in the organization of the Second Annual Leadership Conference. A graduate of Emory University School of Medicine in 1944, Dr. Moore has practiced neurologic surgery in Atlanta since 1957. He is a delegate to the American Medical Association and Vice Chairman of the Council of the Southern Medical Association. He is a former President of the Medical Association of Atlanta and of the Georgia Neurosurgical Society.

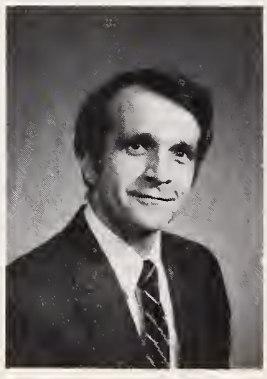
. . . we are confronted with . . . what seems to be a flood of acronyms each threatening, in one way or another, to dilute physician control of the practice of medicine.



Paul M. Ellwood, Jr., M.D. — Dr. Ellwood is the President of InterStudy, Excelsior, Minnesota, an organization which conducts interdisciplinary studies for policymakers, and is Clinical Professor of Pediatrics, Neurology, and Physical Medicine and Rehabilitation at the University of Minnesota. His influence is apparent in a number of issues which are having a profound effect on today's practice of medicine. For example, in response to DRGs and prospective reimbursement, he developed and proposed the concept of a physician-hospital joint corporation called MeSH in 1982; in 1976, he proposed the concept of experience-related medical groups, or PPOs, as a unique approach to cost containment; and in 1970, he proposed the HMO approach to health care, relying on competition and market forces, using HMOs and IPAs, for the Under Secretary of HEW, John Venneman, and President Nixon.



John W. Clarke, M.D. — Dr. Clarke earned his medical degree from the University of Louisville School of Medicine. From 1957-62, he developed the Lakeview Clinic in Waconia, Minnesota, a 15-man multi-specialty clinic, and in 1971 developed its satellite clinic in Jonathan, Minnesota. From 1976-79, he was Vice President of Physician Support Services for the Swedish American Hospital in Rockford, Illinois, and assisted in the develpment of five satellite clinics and the recruitment of 34 physicians. Dr. Clarke is serving as Medical Vice President of Research and Development for Research Health Services in Kansas City, Missouri. In this role, the relationship between the contract physicians of multiple satellite clinics and small rural hospitals with Research Medical Center is of prominent significance.



Paul L. Grimaldi — Mr. Grimaldi is Director of National Health Care Practice, Coopers & Lybrand, New York, New York. Previously, he was with the Department of Financial Management, New Jersey Hospital Association. He holds a doctorate in economics from Fordham University and a baccalaureate in accounting from Manhattan College. His background includes university appointments and positions with state and local government agencies, and he has published articles in a number of health-related journals. He is the co-author of *DRGs: A Practitioner's Guide*.



Charles C. Stamey, M.D. — Dr. Stamey chairs the Governing Council of the MAG Hospital Medical Staff Section and serves as Vice Chairman of the Governing Council of the Hospital Medical Staff Section of the American Medical Association. He practices in Columbus, where he has staff privileges at the Medical Center, a community teaching hospital; Doctors' Hospital, a proprietary hospital; and St. Francis Hospital, a church-affiliated hospital. He is Chief of Staff at the Medical Center and has been actively involved in a variety of committees in each of these facilities.



Thomas F. Frist, Jr., M.D. — Dr. Frist is one of the founders of Hospital Corporation of America. Prior to becoming President in April, 1977, he was responsible for development through acquisition, construction, and new programs and services. He served as President and Chief Operating Officer until August, 1982, when he was named President and Chief Executive Officer. The company currently operates 358 hospitals in 41 states and six foreign countries, with over 85,000 employees and 40,000 doctors on its medical staffs. HCA was founded in 1968, and today is the world's largest publicly owned hospital management company. Dr. Frist received a B.A. degree at Vanderbilt University in 1961 and his M.D. from Washington University School of Medicine in 1965. He completed his surgical internship at Vanderbilt University.

The unofficial theme of the conference is survival during an era of fast and unrelenting change. . . .



Hugh P. Greeley — Mr. Greeley devotes the majority of his time to teaching and consulting in the quality assurance and risk management areas to hospitals, hospital associations, professional associations, and insurance captives. He has served as a consultant to the PSRO program through DHHS in the area of medical care evaluation, to the California Medical Insurance Feasibility Study and the Chicago Hospital Council Risk Pooling Program in the area of risk management, and to the American Hospital Association in the area of quality assurance and trustee responsibility. In the past 8 years, Mr. Greeley has designed or participated in as faculty over 600 educational programs on these subjects as well as medical staff organizations and issues and hospital trustee roles and responsibilities. He served as Associate Director, Education Programs, Quality Review Center, Joint Commission on Accreditation of Hospitals in Chicago from 1974 to 1976; and as Vice President for Professional Services, Kenosha Memorial Hospital, Kenosha, Wisconsin, 1978-1981.

Anxious patients improve in just a few days



And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of the unique benefits of

Valium®

diazepam/Roche

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For a summary of product information, please turn the page.

ROCHE®

Valium® (diazepam/Roche) Ⓝ Tablets
Valrelease™ (diazepam/Roche) Ⓝ slow-release Capsules
Injectable Valium® (diazepam/Roche) Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 or 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V. depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

In vitro studies demonstrate

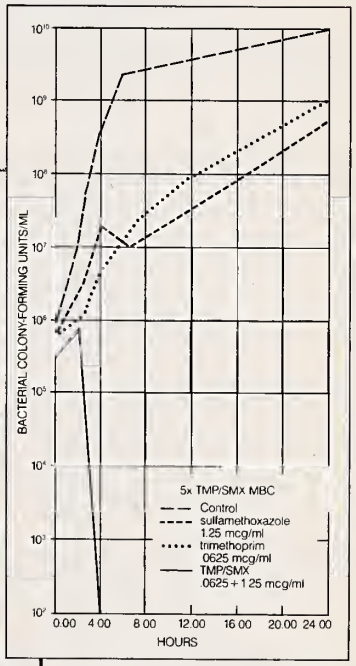
Bactericidal activity with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus* sp.	*Enterobacter* sp.	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofur-antoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI* *



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro*.[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J *et al: Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Iravani A *et al: Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: *Not recommended for infants less than two months of age.*

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Nutley, New Jersey 07110

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BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCAROIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINOICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCAROIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCAROIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCAROIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCAROIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCAROIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PROCAROIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCAROIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCAROIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCAROIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCAROIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

AOVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCAROIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCAROIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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J-9043-4 July 1981

The issue for rural Georgia in the mid 1980s will not be available manpower but will be appropriate recruitment and retention of physicians.

Entry Into Practice: Problems Encountered by Rural and Urban Physicians

M. JULIAN DUTTERA, M.D., GERARD R. HUMMEL, M.P.H., *LaGrange,* and E. EVAN BROWN, PH.D., H. MAX MILLER, PH.D., *Athens**

In 1976, when the Medical Association of Georgia and the Southeastern Institute for Community Health conducted the first Pre-Practice Seminar/ Physician Recruitment Conference, only a limited body of literature describing why physicians leave practice[1] was available. Nor was there much literature relating to identification of characteristics which physicians find desirable in potential practice sites[2, 3] or to problems which physicians encounter on entry into practice.[4, 5, 6]

A study was undertaken in 1980 of primary care physicians in the state of Georgia who had recently entered practice to ascertain the kinds of problems and degree of psychologic stress encountered and the sources of information which were helpful in making the transition from training to practice. This paper deals with specific problems encountered by such physicians, comparing differences between rural and urban physicians.

Methods

This study was based on a sample of physicians in Georgia who were surveyed by mail questionnaire. A sample population was chosen in 1980 on the basis of year of graduation from medical school. An underlying assumption was that all graduates had completed from 3 to 5 years of residency and 2 years of military service before entering practice. Thus, all practicing physicians graduating between 1967 and 1974 were included in the sample frame.

A list of all practicing primary care physicians was obtained from the Composite State Board of Medical Examiners listing themselves in the specialties of Family Practice, Internal Medicine, Pediatrics, General Surgery, and Obstetrics and Gynecology. The entire population of 828 physicians was surveyed by mail questionnaire. Three separate mailings were used to assure an adequate response.

The survey instrument was designed to contain questions on substantive content areas and was divided in four sections. The first section contained questions relating to background characteristics of the physician, including sex, primary and secondary specialty, community size, medical school and year of graduation, year of starting practice, and practice arrangement. A second section contained questions relating to the stressfulness of the transition from the training program to the practice setting and to sources of information which were of assistance in making the transition from the training program to practice. A third section contained questions dealing with the specific problem areas producing difficulty during the first 2 years of practice in the practice setting. Specific areas of concern included geographic and community problems, problems with spouse and family, problems with hospital facilities, and business problems. For analytical purposes, physicians were asked to indicate whether their practice was in partnership or group arrangement or as solo physicians. The fourth and final section invited general comments and asked for the identification of other problem areas not specifically mentioned.

* Dr. Duttera is associated with the Southeastern Institute for Community Health Inc., and is Chairman of MAG's Committee on Access to Health Care; Mr. Hummel is associated with the Southeastern Institute for Community Health, Inc.; Dr. Brown is from the Department of Agricultural Economics, and Dr. Miller is from the Department of Rural Sociology, University of Georgia, Athens, Georgia. Send reprint requests to Dr. Duttera at 303 Smith St., LaGrange, GA 30240.

Statistical Analysis

From the sample population of 828 physicians, 481 questionnaires were returned, for a response rate of 58%. The questionnaires of 466 respondents were usable for data processing, and of this total number of physicians responding, 78 were practicing in communities of less than 10,000 people, 92 in communities of 10,000 to 25,000 population, 109 in communities of 25,000 to 100,000 and 187 in communities having over 100,000 population.

In order to compare the differences between rural and urban physicians and the problems they encountered during the first 2 years in their current practice setting, the 78 physicians practicing in communities with a population of less than 10,000 were compared with the 187 physicians practicing in communities with a population of over 100,000.

Table 1 compares rural and urban doctors with regard to 32 problem areas studied. The medical practitioner in communities of less than 10,000 population cited an average of 5.5 problem areas that were of concern during his or her first 2 years of practice. This number was more than three times the 1.8 average number of problem areas reported by practitioners in communities of over 100,000 population.

Rural doctors experienced a higher percentage of problems in 24 of the 32 areas when compared to urban doctors. Urban doctors experienced an equal percentage of problems in two areas and a higher percentage in six areas. The two problem areas where an equal percentage of problems were experienced appeared to be minor problems for both rural and urban doctors. These were: 1) cooperation of available consultants for clinical problems, and 2) terrain. The six problem areas in which urban doctors had proportionally more problems were: 1) limited need and demand for services (15% vs 11%); 2) income potential (10% vs 7%); 3) opportunity to influence community affairs (8% vs 6%); 4) cooperation of local lending institutions (8% vs 5%); 5) climate (4% vs 3%); and 6) credentialing limitations (5% vs 0%).

Of the 17 problem areas where rural physicians had a significantly higher percentage response than urban physicians, the following seven areas had a rate three times greater: 1) adequacy of hospital facilities; 2) availability of professional colleagues and associates; 3) opportunities for professional education; 4) isolation; 5) emergency room coverage; 6) personalities and practice styles of physicians in the local community; and 7) art and cultural activities. The other 10 areas are shown in Table 1.

Table 2 contains chi-square values reflecting differences between rural and urban physicians in their perceptions of community-related problems. These problems were considered to be related to the community and were classified for analytical purposes as being practice related, family related, and general in nature.

TABLE 1 — Thirty-two Problem Areas Encountered During the First 2 Years of Practice by 78 Medical Doctors Practicing in Communities of Less Than 10,000 Population Compared to 187 Medical Doctors Practicing in Communities Having More Than 100,000 Population — Georgia, 1980

Problem Areas	*Percentage of Doctors Having Problems* Under 10,000 Population	Over 100,000 Population
1. Adequacy of hospital facilities	42*	5
2. Availability of professional colleagues & medical associates	40*	5
3. Opportunities for professional education	36*	9
4. Isolation	36*	10
5. Emergency room coverage	35*	7
6. Personalities & practice styles of physicians in local community	33*	14
7. Adequate time off	32	26
8. Art & cultural activities	31*	10
9. Size of community	24*	4
10. Availability of consultants for clinical problems	24*	5
11. Special needs of spouse	22	19
12. Excessive need & demand for services	22*	6
13. Compatibility with hospital staff	19*	3
14. Willingness of professional colleagues to assist in transition to practice	15	9
15. Education system	14*	6
16. Acceptability of location to spouse	14	10
17. Church & religious activities	12*	4
18. Special needs of children	12*	5
19. Progressiveness of local hospital administration	12*	5
20. Distance to hospital	12	10
21. Limited need & demand for services	11	15†
22. Employment opportunities for spouse	8	5
23. Education opportunities for spouse	8*	2
24. Availability of child rearing facilities	8*	2
25. Income potential	7	10†
26. Opportunity to influence community affairs	6	8†
27. By-laws limitations	5	4
28. Cooperation of available consultants for clinical problems	5	5†
29. Cooperation of local lending institutions	5	8†
30. Climate	3	4†
31. Terrain	1	1†
32. Credentialing limitations	0	5†
Average of 32 Problem Areas	17.3%	7.5%
Average Number of Problem Areas	5.5	1.8

* Areas in which rural doctors had statistically significant differences compared to urban doctors.

† Problem areas in which practitioners in the more urban areas had the same or greater degree of concern compared to the more rural doctors.

Discussion

When problems which rural physicians encounter on entering practice are analyzed, particularly those

TABLE 2 — Chi-Square Values Reflecting Differences Between Rural and Urban Physicians in the Perception of Community-Related Problem Areas

Problem	*Chi-Square*	*Probability (df = 1)*
PRACTICE RELATED		
1. Adequacy of facilities	52.8	<.001
2. Distance	.11	n.s.
3. Isolation	27.34	<.001
FAMILY NEEDS		
1. Needs of children	3.62	<.10
2. Education opportunities for spouse	4.24	<.05
3. Special needs of spouse	.09	n.s.
4. Availability of child-rearing facilities	4.24	<.05
GENERAL		
1. Art and culture	11.96	<.001
2. Educational system	7.57	<.01
3. Church	5.47	<.02
4. Cooperation of local lending institutions	.92	n.s.

which are seen significantly more frequently than urban physicians, four categories of problems arise. The first category is a series of problems which are community related and cannot be easily manipulated by the physician once he arrives in the community and thus, clearly must be dealt with by the physician. These problems include such issues as adequacy of the hospital facilities, isolation, and distance to the nearest hospital.

It is clear that many of these problems must be recognized as potentially significant with regard to a physician's practice. Adequacy of hospital facilities and need and demand for services might be issues that can be dealt with over time but their solutions should not be expected on an immediate basis. The problem of isolation expressed by 36% of the rural doctors more than likely refers to professional isolation, not necessarily geographic isolation. This problem area is closely related to another problem frequently cited, the availability of professional colleagues and medical associates. This problem was reported by two out of five rural practitioners. At present, there are no active programs in Georgia aimed at ameliorating the sense of isolation from one's professional colleagues. Local county medical associations holding regular meetings in conjunction with surrounding medical associations is one suggestion. Another method might be to have regularly scheduled weekend retreats for physicians in a number of communities where formal and informal meetings are to be held.

The second category of problems are those which are practice related, including such issues as opportunities for professional education, emergency room coverage, adequate time off, and personality and practice styles within the local community. These are problem areas where hospital administrators and local medical societies can have a significant impact. Individual physicians within the medical community as a whole can certainly assist with these issues. The single largest resource for the physician making the transition from training to practice is an established physician in the community where he chooses to practice. According to the results of the study, this individual has played an important and unrecognized role in assisting the young physician entering practice. Perhaps the obvious importance of the role of an established physician in this setting should be recognized and formalized in terms of a committee of the county medical society, particularly in rural areas, to ease some of the problems which have now been identified.

The third series of problems are family related, and includes educational needs, needs of the spouse, and child-rearing facilities. These problems should be considered during the time when the physician is investigating the possibility of locating a practice in a particular community.

This would prevent the all-too-familiar cycle of recruiting a new doctor only to see him leave within a 6-month to 2-year time period. A community task force to deal with transitional problems of new physicians and their families should be established to prevent the problem of physicians leaving their practices.

Rural doctors experienced a higher percentage of problems in 24 of the 32 areas when compared to urban doctors.

The fourth category includes a series of general problems related to art, culture, education, and religion. Thirty one percent (31%) of rural physicians compared to 14% of urban physicians listed the lack of art and cultural activities as a problem area. This is not surprising unless one happens to be located near a large metropolitan center or large university. Generally, efforts to bring such activities into small communities receive little support. Formal education is also an issue. A significant number of rural physicians listed church and religious activities as a problem. Rural areas usually have more traditional protestant sects and pentecostal evangelical sects. This limitation of choice makes it difficult for members of other faiths to find places of worship and to engage in other church-related activities.

In looking at rural practice opportunities, the physician is faced with a series of problems, some of which must be dealt with prior to entry into practice, some which can be dealt with by the physician and other members of the medical community after entry into practice, and some of which can be helped by the community and its leaders.

Problem areas where the physician cannot expect to make changes within the first 2 years must be scrutinized closely. If these areas are not recognized and the physician finds himself with basic incompatibilities, the only alternative is to leave the community. Other issues can be clearly helped by community physicians, hospital administrators, and civic groups. It appears that a physician colleague to aid in the transition and act as counselor or advisor is a phenomenon that has occurred within the practice community without much formal recognition. These informal physician advisors are the single largest and most helpful source of information for the physician making the transition into practice.

It also appears that a community task force to deal with non-practice and non-medical related issues would be a very helpful addition to assist in the physician's transition into practice. Only a rapid integration of a physician into a community, a community network of friends, community organizations, and church activities would seem to address other clearly identified problems. These issues become all the more important when one realizes that the availability of physician manpower within the state of Georgia and across the United States is changing drastically. Medical school enrollment has almost doubled within the last decade. The state of Georgia now has training programs which are diversified geographically across the state and are no longer situated only in the major metropolitan areas. There are now family practice residency programs in Rome, Columbus, Augusta, Savannah, and Macon; whereas training programs formerly existed only in Atlanta and Augusta. In addition, the availability of the National Health Service Corps scholarships to which a large number of physicians have subscribed made rural practice and other unserved areas mandatory for a large number of physicians who complete their training in the 1980s. The issue for rural Georgia in the mid 1980s will not be available manpower but will be appropriate recruitment and retention of physicians. The problems defined above and the identification of those which are amenable to manipulation within the community provides a framework within which rural physicians and rural communities can work together to recruit and retain physicians.

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RU-TUSS® II
sustained release capsules

Before prescribing, see complete prescribing information. The following is a brief summary.
DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.
INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).
CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.
Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.
Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.
WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.
Usage In pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.
PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated intestinal obstruction, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).
Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.
ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.
Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.
Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.
Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.
Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis histeria, neuritis, convulsions.
Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.
Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.
Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.
DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.
OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.
Treatment: The patient should be induced to vomit, even if emesis has occured spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.
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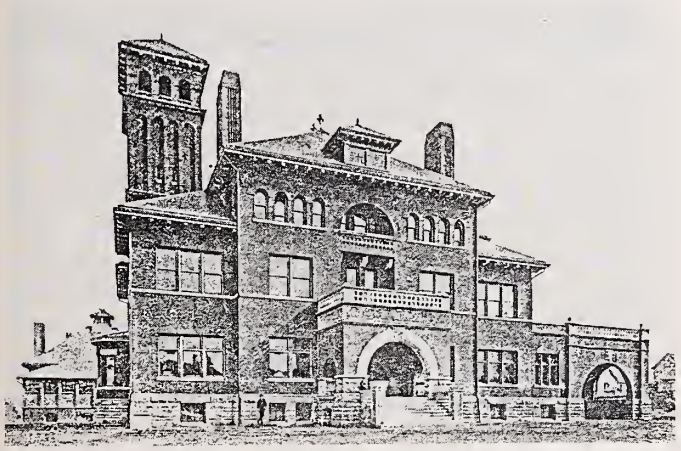
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A look at Grady's formative years and at the men who participated in them.

Atlanta's City Hospital Had a Rough Beginning

EVELYN WARD GAY, ***Decatur****



Grady Memorial Hospital, Atlanta, 1892.

GRADY MEMORIAL HOSPITAL in downtown Atlanta has had its ups and downs over the 91 years of its existence, but few of them have equalled the traumatic events that occurred during the first 6 months of its operation. At least two of the characters who took part in the drama have earned a place for themselves in history.

High Aspirations

For most inhabitants of the city, it all began on May 25, 1892, with a front-page headline in *The Atlanta Constitution* — "The Grady Hospital — That Magnificent Charity Will Be Formally Dedicated Today." The ceremony was set for 4 p.m., and the building was called "an ornament to Atlanta which will be pointed out in years to come as one of the chief attractions of the city." In order that the people would have no trouble finding the new structure, they were given directions to "Butler Street, between Jenkins and College, just below the old Atlanta Medical College." They also were told: "The Edgewood electric line passes within a block of the hospital."

Dr. A. W. Calhoun was reported to have said that the operating room, where medical students must pay a fee to watch an operation, was "the best he had ever seen." Subsequently, it was described as being high-vaulted, circular in shape, with a gallery of seats rising in the style of an amphitheater, "coming down to a point in the center of the room where the operating chair is located and where light from the upper windows falls brightly upon the patient."

The next day, *The Constitution* told the people, "It's the city's now." A part of Mayor W. A. Hemphill's speech of acceptance was quoted: "This bright May day sun is an omen to this institution. It prophesies a splendid future for the Grady Hosptial. . . . It marks a new era in the history of our city — an era of prosperity and growth that will far exceed the measure of our past achievements. . . . "

Captain J. W. English, President of the Board of Trustees, said: "I consider Grady Hospital the grandest institution that was ever founded in Atlanta. It will nurse the poor and rich alike and will be an asylum for the black and white."

Joseph Hirsch, a wealthy Atlanta businessman, had been chairman of the building committee, which was made up of several gentlemen, including Dr. A. W. Calhoun and Dr. H. P. Cooper. Physicians in charge of the hospital would be, in addition to Drs. Calhoun and Cooper, Drs. A. G. Hobbs, J. G. Armstrong, W. S. Elkin, W. P. Nicolson, C. G.

* Mrs. Gay is Chairman of the Research and Romance of Medicine Committee of the Auxiliary of the MAG. Her address is 911 Vistavia Circle, Decatur, GA 30033.

Giddings, J. G. Earnest, H. Bak, J. F. Alexander, W. S. Kendrick, J. S. Todd, R. B. Ridley, R. O. Hardon, and G. H. Nobles.

Cost of the hospital, including the lot, was estimated at $105,000. A debt of about $400 remained outstanding, but it was hoped that citizens would send in their checks soon to cover that amount.

An editorial in the same newspaper that day said that the hospital had "passed through its share of trials and struggles before getting fairly on its feet." Mr. Hirsch received most of the credit for the building's completion, having given his "heart, hand and purse without stint." The editorial concluded: "Atlanta is proud of her hospital. Its erection shows that in this rushing and busy capital of progress, our people do not lose sight of the suffering and the unfortunate."

On June 2, *The Constitution* headlined: "It Opens Today." Formal opening, it said, had been delayed from the day before because several important items of equipment had not been received in time. The hospital was described in greater detail as having long corridors with many glass windows. The reason for the length, it was explained, was to place the wards at as great a distance apart as possible to prevent spread of any infectious disease. Large windows were to furnish sun baths for patients as well as light. The rooms were called "large and well ventilated with all corners curved and polished to prevent the collection of germs and microbes."

One of the board members of the hospital said of the land on which it was built: "This is a remarkable instance of how property in Atlanta has increased in value." He revealed that the owner, Colonel L. P. Grant, had at first asked $13,500 for the 4 acres of ground, but had reduced that amount by $1,000 when he learned of the purpose for which it was desired. He then admitted when the deed was being examined that he had paid only $4.50 an acre for it when it was "all in woods."

But the small sum of money which had been lacking a few days before had now been paid in full. For cancellation of the debt, the trustees were grateful to the city's locomotive engineers who had raised $300 at their convention the past week. A ball game at the city park netted the balance and "the hospital, therefore, begins its work today unclouded and unembarrassed."

The institution, however, was not to remain unembarrassed for long.

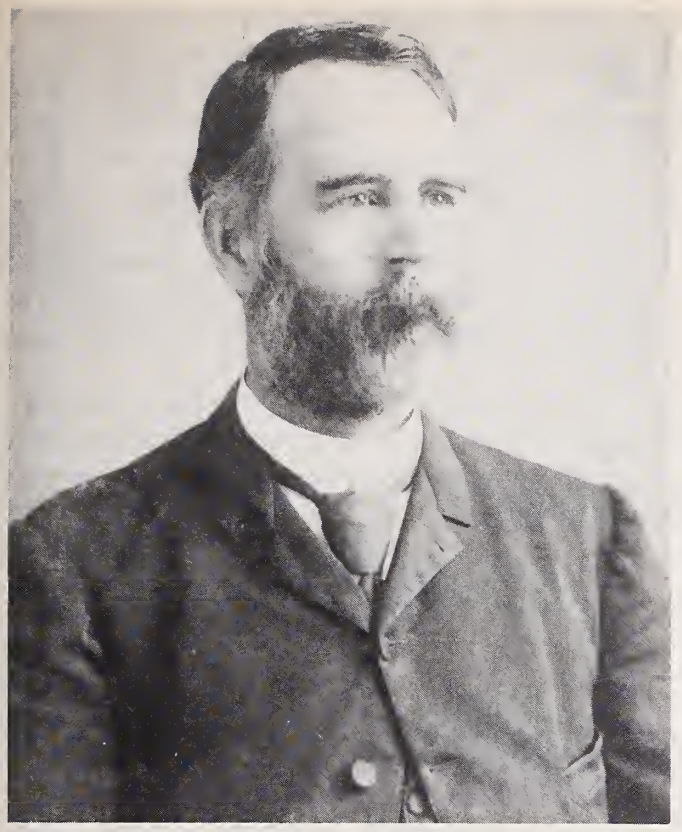
First Superintendent

It was announced that day that the superintendent of Grady Memorial Hospital would be Dr. A. Fensch, "a gentleman of cultured manners and a liberal education." A native of Germany, he had spent the greater part of his life in America, having been employed for 14 years in Army hospitals run by the United States government, and had organized the hospital at Fort McPherson on the outskirts of Atlanta just 3 years before. He was said to hold diplomas from two medical colleges, and had practiced medicine "in its different branches." He had traveled extensively in the West, and had fought under the U. S. flag in several encounters with the Indians, one being that in which the celebrated Indian chief, Geronimo, had been captured. He carried on his person "a frightful scar in testimony of his gallant service to this country."

The new superintendent announced that he had 18 people already at work, principally engineers, cooks, chambermaids, and janitors, and expected the nurses to report the next day. He pledged to aid the trustees in every way to make Grady "the first institution of its kind in America."

To outward appearances, all went well with the new hospital for several months. But on Monday morning, October 31, 1892, *The Atlanta Constitution* ran another headline, "The Unexpected," followed by a sub-head reading, "Dr. Fensch's Resignation is Accepted by the Board." The story gave all the complicated details. "The Grady Hospital finds itself without a superintendent," it began. A meeting of the Board had been called for the previous Saturday to consider "a problem." Dr. Fensch, it seems, had tangled repeatedly during the 5 months past with Dr. H. L. Gill, called "a splendid young man who had just graduated with honors from the Southern Medical College and held the position of head house physician."

A wide difference in temperament and training of the two men was given as the reason for the conflict. Dr. Fensch's military training, about which everyone had heard so much, had not suited the kind and gentle Dr. Gill who had objected to the older man's loud abuse and his cruelty to charity patients, as verified by two of the nurses. On several occasions Dr. Gill had suffered the indignity of being called "a subordinate with no authority to make medical decisions" in the presence of patients. As a result, the many disagreements between the two men had caused two factions to develop among other hospital workers. When charges were filed against the superintendent, Dr. Fensch made some quick accusations against Dr. Gill, such as his habit of laughing and talking with the nurses on the wards, and on one occasion that his shoes had made too much noise in the hallways. The trustees, however, refused Dr. Fensch's request to fire the younger man on such petty charges, and he in turn offered his resignation. The end result was that the trustees accepted the superintendent's resignation and asked for Dr. Gill's resignation as well. Dr. P. B. George, one of the other house physicians, was named temporary head



Dr. Tomlinson Fort Brewster was Grady Hospital's second superintendent and served for 14 years.

of the hospital until a permanent superintendent could be appointed.

Second Superintendent

About a month later, Dr. Tomlinson Fort Brewster began a notable tenure that would last for 14 years and see the hospital through its turbulent first decade.

The new man brought with him a background and personality as colorful as those of Dr. Fensch. Born at Canton, Ga., on June 4, 1834, just 4 years after Georgia laws were extended into Indian lands in North Georgia, and 4 years before the Cherokees were deported from the area, he had spent his childhood in an unsettled time. A letter written by his father, Dr. John Brewster, to Governor Lumpkin at the state capitol in Milledgeville less than a month before the baby was born, revealed vividly the climate of fear and desperation into which the family had moved. Dated May 16, 1834, it told how the Indians from their nearby village called Sixes Town harassed the new settlers around Sutallee, Ga., by robbing them of horses and other possessions, destroying gardens, and shooting arrows into the livestock.

In this atmosphere, Tomlinson Fort Brewster, named by his father for Georgia's celebrated Dr. Tomlinson Fort, grew to manhood and studied medicine for 3 years as an apprentice to a relative, Dr. B. D. Brewster. He then left for Philadelphia at the age of 18 to attend his first session of study at the Jefferson Medical College, signing the register there on October 28, 1852. In 1854, while still a minor, he came home and was granted a license by the Georgia legislature to practice medicine in Cherokee County without taking an examination. Returning to Philadelphia the next year, he was graduated with an M.D. degree from the medical college with the class of 1856.

Back in Harris County, Ga., Dr. Tomlinson Fort Brewster married and began a practice which lasted for 30 years — interrupted only by military service in the Civil War. That experience, however, would test the young doctor's courage and prepare him for leadership in his later life. As a First Lieutenant in Company H, 54th Georgia Infantry Volunteers, he was stationed at Beaulieu near Savannah when an arrogant superior officer accused him 1 day of wishing that he could get out of the service "for fear of a bullet and love of a dollar." Lt. Brewster called Colonel Charlton H. Way a liar. He was arrested and "deposited for safe-keeping," as he called it, in the Oglethorpe Barracks until his case could come to trial. His wife, Maggie, went to Savannah to try to help him out of his predicament and boarded at the home of the Jacob Miller family on South Broad Street.

Both Lt. and Mrs. Brewster appealed by letter to a friend, Colonel H. H. Waters, who was on Governor Joseph E. Brown's staff, telling of the "mean and unscrupulous persecution" he was being forced to endure by those of superior rank, and the unduly severe terms and restrictions placed upon him which were not warranted by military law. He was advised in return that his case, including evidence of his good character, had been laid before the Secretary of War.

Nevertheless, Lt. Brewster was brought up for court-martial before a military tribunal held at Charleston, S. C., on December 4, 1863, found guilty of all charges read, and sentenced to be dismissed from service in the Confederate Army. Thereafter, on December 20, 1863, he was conscripted as a private and detailed by order of General Gilmer to serve as a hospital steward at Beaulieu for 53 days at 25¢ a day, to begin on January 1, 1864. However, he was sent later that year to the Walker Hospital at Columbus as an Acting Assistant Surgeon and appointed to a board to examine all convalescents there and return to duty all who were fit for field service.

Following the war, he returned home to practice medicine and was also twice elected to the Georgia legislature. In 1871, he became a member of the Medical Association of Georgia from Harris County.

By the beginning of the Gay Nineties, Dr. Brewster had had a taste of city life. He moved to Atlanta

and for a short time was an agent for the Brooklyn Life Insurance Company of New York before opening an office to practice medicine at 33½ Whitehall Street. He boarded at the "Grant House."

At the November 8, 1892, meeting of the Board of Trustees of Grady Memorial Hospital, applications from Dr. Brewster and a Dr. Thrasher were considered for the replacement of the controversial Dr. Fensch. The medical staff had recommended Brewster but the motion was tabled for the moment. Shortly thereafter, Dr. Brewster was named to the post to begin his long record of service.

Hospital Perspectives

The years ahead were not to be without problems for the new superintendent. In 1895, when a friend of the family died of consumption, leaving her 7-year-old daughter an orphan, Dr. Brewster became foster father to the child and took her to live with him at Grady Hospital. Little Rose Word was the daughter of Frank Word and the former Roselle Barbour, of Rome, and the granddaughter of Dr. Thomas Jefferson Word who had been mayor of Rome at the beginning of the Civil War and was a brother-in-law of Dr. H. V. M. Miller, professor of obstetrics at the Atlanta Medical College. The young mother had come to Atlanta a short time before her death to open a photography shop on Whitehall Street not far from the former office of Dr. Brewster. The little girl became a sort of mascot at the hospital, often riding the ambulance horses and being a favorite with Grady doctors. At a very young age she met and married James Arthur Manning, "the boy next door" on Butler Street.

By 1900, the hospital seemed to be running smoothly. A report made by Brewster on December 31 of that year (his 8th annual report and the hospital's 9th) showed that there had been 234 paying patients and 2,136 charity patients during the past year, for a total of 2,370. The daily average of patients in the hospital had been 79, with cost per patient of $1.13. Ambulance runs had numbered 2,140. Total yearly expenses to the city had been $28,375.88. The entire nursing staff consisted of four graduates of the Nurses Training School and 19 pupils.

In 1906, the hospital's 15th annual report showed 3,045 patients treated, 1,178 of them called "outdoor cases," and the daily average of patients treated had increased to 87. Net expenses amounted to $40,964.20. The gross daily cost per patient was $1.50, the net $1.12. There had been no change in personnel on the Board of Trustees, but the medical board had suffered the loss of Dr. Charles D. Hurt by death, and the vacancy had been filled by the election of Dr. Rufus T. Dorsey, Jr., professor of medicine at the Atlanta Medical College. An ambulance and 2 new horses had been added during the year, but there was still need for a fence to enclose the entire grounds. Dr. Brewster acknowledged the "uniform courtesy and consideration" he had received for another, the 14th, year of his encumbency.

Six months later, on June 11, 1907, he resigned because of ill health, and Dr. J. G. Earnest moved that a resolution be drafted setting forth the medical board's sincere appreciation of the "long and faithful and very efficient service" of Dr. Brewster as retiring superintendent. The motion was unanimously carried and the president named a committee to draw up same. Dr. Brewster moved out of Grady Hospital and went to live with his foster daughter and her husband. He died of nephritis at Grady Hospital on May 1, 1910, at the age of 76, and was buried at Oakland Cemetery.

In the years since Dr. Brewster's tenure, Grady Hospital has seen several more superintendents come and go, but few of them have been physicians. There have been many changes at the downtown institution. In 1959, a new 16-story hospital was constructed and put into operation on an adjoining site, and under the control of the Fulton-DeKalb Hospital Authority and as a teaching arm for many years of the Emory University School of Medicine, the hospital's reach has been extended far beyond the confines of the city.

Currently, the yearly average of patients seen at the hospital is 350,000. In 1982, modern motorized ambulances covered 618,051 miles, making 35,049 regular calls. The hospital also furnishes ambulance service for 498 stretcher patients who must come in for regular care. Today, in 1983, Grady Hospital's budget is approximately $116,000,000.

Acknowledgments

Acknowledgment is made to Arthur Brewster (Bruce) Manning, of Jacksonville, Fla., son of the former Rose Word, and a former newspaperman on *The Atlanta Constitution,* for sharing his family research, including many important documents and photographs; and to Ms. Beverly Thomas, Director of Public Relations at Grady Memorial Hospital, for current statistics.

A plea for rational and cooperative health care financing — comments on the Participating Physician Agreement proposed by the Atlanta Blues.

The Team Needs a First Baseman

CHARLES R. UNDERWOOD, *Marietta*

THE RECENTLY PROPOSED "Participating Physician Agreement" developed by Blue Cross and Blue Shield of Georgia/Atlanta, Inc., has been met by the medical community in Georgia with something less than motherly compassion and fatherly understanding. There have been honest questions raised concerning the program bred out of misunderstanding of its exact details and easily rectified by clarification. There have been well founded objections to the program based on clear understanding of its nature. There have been accusations of ruthless and selfish conniving on the part of the company to protect its own self-interests against the covered population as well as the physician and the hospital. Of importance, there has been a willingness on the part of the physicians to listen to explanations and to give some thought to the matter of health care financing as it is addressed in this proposal.

Perhaps one needs first to realize that a "Participating Physician Agreement" is neither new nor innovative nor radical — it isn't even very exciting and for the amount of debate it has engendered, hardly controversial or deserving of such attention. It is new only to the extent that the Atlanta Plan represents one of the nine remaining Blue Shield Plans in the entire Republic that does not have such a "Participating Physician Agreement." Not new to the extent that over one-half of the geographic state, that covered by the Columbus Blue Cross and Blue Shield Plan, has for 30 years functioned with such an Agreement, with 80 percent of the physicians in that geographic area participating. It needs, as does any legal document or other mystifying entity, to be reduced to its bare essentials and looked at with an unbiased but calculating eye.

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The plan first asked that you "set your own fees" in the context of a "usual, customary, and reasonable" schema. It does not propose that Blue Cross and Blue Shield of Georgia/Atlanta promulgate a "fee schedule" but that we physicians develop that array of charges on a day-to-day basis as we go about our usual confusing methodology of trying to balance costs against income in our daily practice. It will pay to us the 90th percentile of all the charges for any particular treatment entity, only reducing those charges above that 90th percentile to this common level. I have sat on enough Foundation Peer Review Panels in this State to have become keenly aware of the fact that there are individuals in our midst who have no concept of their worth — no valid concept, that is, that this worth for their services must in some way be relative to comparable services rendered by the rest of us. We have said on those panels time and time again that something should be done about that individual who in some way has failed to develop a sense of worth relative to the services which he renders to the unhealthy public. And so the Plan simply does something about that group of people. This aspect of the matter will have impact on less than 10 percent of us, and perhaps it will be the 10 percent of us who need some help in understanding these matters.

It has been said that the Plan allows the "company" to unilaterally alter the agreement without consultation with the individual physician — and this is true. The protection, pure and simply, is an honest and trustworthy company with a Board of Directors comprised one-third of physicians, themselves the selection of the organized medical community. At some point in this world, one has to place trust in some person or some thing. Should the system be abused, then the physician simply turns to his 30-day withdrawal clause and abandons the entire

undertaking.

There are many other aspects of the Participating Physician Agreement that have been taken to task — and too many to deal with in detail here. When, however, they are looked at with an understanding eye, they become clearly an effort by an informed and conscientious "third party payer" to take the interest of the patient seeking the best of health care but with a limited budget, the interest of the hospital and the physician in maintaining a fiscally sound structure, and the needs of a business such as Blue Cross and Blue Shield of Georgia/Atlanta to be efficient and successful in the marketplace of the insurance carrier — to take these things and mold them into a fair and functional arrangement. We physicians need sometimes to stop and take a careful look at ourselves. Are we really primarily interested, as we have said for so many years, only in the welfare of the patient, protecting him from unfair financing mechanisms and providing to him the very best of medical care? Or do we really have a deepseated and seldom expressed compulsion to maintain our autonomy — our "fee-for-service system" — at the expense of the other complex and contributing components of the health care picture? We need to carefully ask ourselves if we object to this "Agreement" because it really fails to answer the problems of the health care delivery and financing system. Or do we object to it because it infringes on our ability to be independent operators outside the realm, outside the control, of the other players on the "Health Care Team"? We need to ask ourselves if we have reached a point in time where the "delivery of health care" needs a new "manager" — or else an amalgam of managers comprised of physicians and hospitals and third party payers. We need, perhaps, to ask ourselves if the time has not arrived for us to be the first baseman on the team and not the manager — and play the position so well that the rest of the players come to us for advice and for help. Have we played King Lear too long? Marshalled and commanded and directed our legion of forces until the daughters which we bore turn upon us, asking not for counsel and love and understanding, but demanding rather the reins of control which for so many years we held? Is the road back to sanity and to cooperative "managing" of the health care delivery system not one of physicians (and yes, of third party payers and hospital administrators) realizing that no longer can we function, nor can we afford to function, in a system wracked by divisiveness and characterized by lack of compliant and cooperative understanding? One thing does seem clear, however, and that is the utter necessity that somebody function efficiently at every position on the team. Someone has to play first base, and perhaps we can do it. If so, they may even come someday and ask our help and our opinion, much as the butterfly, which if you pursue it, is always beyond your grasp, but if you sit quietly may come and light upon your shoulder.

editorial
editorial
editorial

A Current Perspective on Homosexuality

WHAT DOES OBESITY have to do with homosexuality? Nothing. But we can use obesity as a model to talk clinically about homosexuality. If you are obese, you are not necessarily sick, and you can lead a contented life. There are lobbying groups who seek to diminish social prejudice against the overweight. Still, obesity does limit you physically and make you more prone to certain diseases as the years go by, such as diabetes and hypertension. And if the desire and motivation exist, you can do something about obesity by dieting, getting more exercise, using appetite suppressants, etc. You have a choice.

Homosexuality, like obesity, is something the individual can do something about. The homosexual is not necessarily "sick" and can lead a satisfying life, but there are certain limitations. Homosexuality deprives the individual of the sense of posterity that family and children provide. While young and physically vigorous, there is no trouble finding relationships. With advancing age, it is not so easy. Psychiatrists see many older homosexuals nowadays who are lonely and depressed.

If you are a male homosexual, and the desire and motivation exist to overcome a deep-seated fear of women, that choice is available through psychoanalysis. The statement that, "I was born that way and will be so forever," is a myth and untrue on both counts. No matter how intense the lobbying effort that homosexuality is an "alternate lifestyle," society will always retain a "prejudice" against any practice that, carried to the ultimate, means decline of the species. We have all seen enough National Geographic films to know the extent to which nature goes to insure that every species will reproduce itself.

Homosexual behavior represents a "psychological defense" which helps one cope with tension and anxiety growing up.[1] A family in which the mother is domineering and threatening might cause the boy child to learn to avoid intimate contact with women so he will feel safe. Or, in a home without a significant father, the boy has difficulty envisioning himself as a mature male and may spend a lifetime trying to incorporate other men's maleness. (I will deal with aspects of competition later.)

There is no evidence that homosexuality is genetically transmitted. We do know that hormones influence activity and passivity in newborns; baby girls whose mothers were given male hormones to maintain pregnancy tend to be more active than infants who were not subject to this hormonal influence. Activity and passivity are a long way from homosexual inclination.

John N., a gifted and handsome man of 36 and comptroller for a middle range corporation, began analysis several years ago after his company had been merged into a large conglomerate. Now, he had a woman supervisor. He prepared his reports minutely, rehearsed everything he would say ten times, but he stammered and sweated and flushed in her presence.

When he was seven, his father had run off with another woman, leaving the wife, our patient, and a 4-year-old sister behind. The mother forbade the father from visiting. She insisted the boy study hard at school and that he learn to play the

harpsichord. He did not date as an adolescent and was preoccupied with the feeling that he was a homosexual. As an adult, he spent his days at work, his evenings as volunteer music librarian for the local symphony, and weekends visiting his sister, her husband, and their three young children. He had no friends, male or female. Four or five times a year he would fly to San Francisco and find young men to have sex with him for pay.

One day he started shivering on the couch. I thought he was having fever and chills, but this was not the case. I invited him to sit up or pace about, but he declined. The shivering continued unabated. He then recalled that when he was 13, his mother told him she hated body hair. (This symptom is not as unusual as it sounds. A child exposed prematurely to adult sexual anatomy may harbor a fear of body hair.) She came into his bathroom once or twice a month, made him extend his arms, and shaved the hair from his armpits with a razor. These rituals petrified him, and they continued until he was 16 and spent a summer at camp. He refused after that.

If homosexuality is considered an alternate lifestyle, people who consider themselves homosexual will be less inclined to seek treatment. . . .

The patient began to analyze these experiences with his mother and how they were reflected in his life today, including attitudes toward his new supervisor. He became more comfortable in his relationship with her and reported a growing mutual respect. Later that year, he met a pianist, began dating her, and married happily. They now have two children.

This clinical vignette leads to an obvious question: if homosexuality were inborn, how could we effect these changes? Moreover, we must distinguish between *transsexualism, transvestism,* and *homosexuality,* three different entities with different developmental roots.[2]

An infant is cared for mainly by mothers or other women, and, after several months, he begins to become progressively aware of his own personal identity as distinct from theirs, and to assert himself. This self-assertion may be impeded in families where the mother turns to the infant son for fulfillment; she may feel compelled to do this because she is depressed, or involved in non-gratifying or sexless marriage. This child retains a total physical and emotional identification with the mother. In fact, he feels that he is a direct extension of her. He grows up hating his maleness and male sex organs and seeks surgery to construct female anatomy. These reactions represent the syndrome of *transsexuality*. Transsexuals generally avoid sexual contact.

The infant who is able to distinguish and differentiate himself physically from his mother and develop a core gender identity as a male, but still feels guilty about his sexual (sensual) feelings toward the mother during childhood and adolescence, may displace the sexual interest from the person onto clothing. This is the *transvestite*. The purpose of the cross-dressing is sexual arousal. Unlike transsexuals, transvestites acknowledge their manhood and frequently take on hyper-masculine jobs where there is constant competition with other men.

The *homosexual* accepts his maleness, seeks erotic gratification through sexual activity with other men, and frequently expresses nonsexual needs through his homosexual relationships. When his mother has been dominant, or the father distant, the son seeks homosexual contacts as a way of attaining intimacy, dependency, and a feeling of self-worth.

We occasionally hear of a married and family man engaging in homosexual activity. Phil was 32 when twin sons were born. One day he was in the men's room at a hotel when a man his age made a sexual overture. Phil felt he could not resist, and the two of them went to a private area where they had sex. Phil's behavior could be a reaction to his new responsibility as a father — competition with all adult men,

including his own father. Through homosexual activity, he symbolically submits to the other man and withdraws from this competition. Some clinicians separate homosexual behavior based on fear of competition from that derived from fear of an overpowering female.[3]

Concern today about the recently described immune deficiency syndrome, AIDS, has heightened interest in homosexuality. Each day's news reports bring further evidence of the severity of the disease. Blood donations have fallen off because of the fear that giving blood might expose the donor to AIDS; fortunately, that myth is now being put to rest.

Since male homosexuals are the most targeted group for contracting AIDS, news stories tell of their many fears: how to change one's lifestyle to minimize exposure. Should one change jobs? or roommates? or clubs? One element seldom discussed publicly: male homosexuals can also modify their lifestyle by dealing with the fear of commitment to a woman.

Indeed, powerful groups within the medical and psychiatric community insist that the physician accept homosexuality as an alternate lifestyle. A pediatrician who identifies himself as a homosexual has written, "It's the job of the doctor not to have anything to say about the sexual unfolding of the child. The child may develop homosexual or heterosexual; the doctor stands out of the way."

Also, Dr. John Spiegel, President of the American Academy of Psychoanalysis, decried, ". . . the almost complete, dead silence on the question of homosexuality as a normal variant in human behavior, despite the decade that has passed since the American Psychiatric Association eliminated homosexuality as an illness," in his 1982 presidential address. Spiegel chastised psychiatrists for being "homophobes." (In 1974, the American Psychiatric Association voted to delete homosexuality from the category of disordered behavior. If the syndrome was deleted by total membership vote, it could be reinstated by vote; many letters to psychiatric journals today call for such a referendum.)

We have traveled full circle with homosexuality. Two decades ago, the barest hint that a "straight" man was homosexual might cause him to respond with physical attack; today, to suggest that someone who labels himself a homosexual could become heterosexual might also provoke a vigorous response. At the very least, there would be a "lecture" that homosexuality is an alternate lifestyle available to everyone.

If homosexuality is considered an alternate lifestyle, people who consider themselves homosexual will be less inclined to seek treatment; treatment for those who do seek help will be more difficult. As psychiatrists, we understand the basis for homosexual behavior and insist that homosexual individuals be neither persecuted nor prosecuted. But I also contend that society must consider homosexual behavior as deviant (different) just as we consider obesity deviant. Both homosexuality and obesity can limit the range of life's excursion and can predispose the individual to physical illness or loneliness and mental depression later in life. All of us have a stake in upholding heterosexuality, marriage, and the family just as we uphold good physical health; for in them lies the future of humanity.

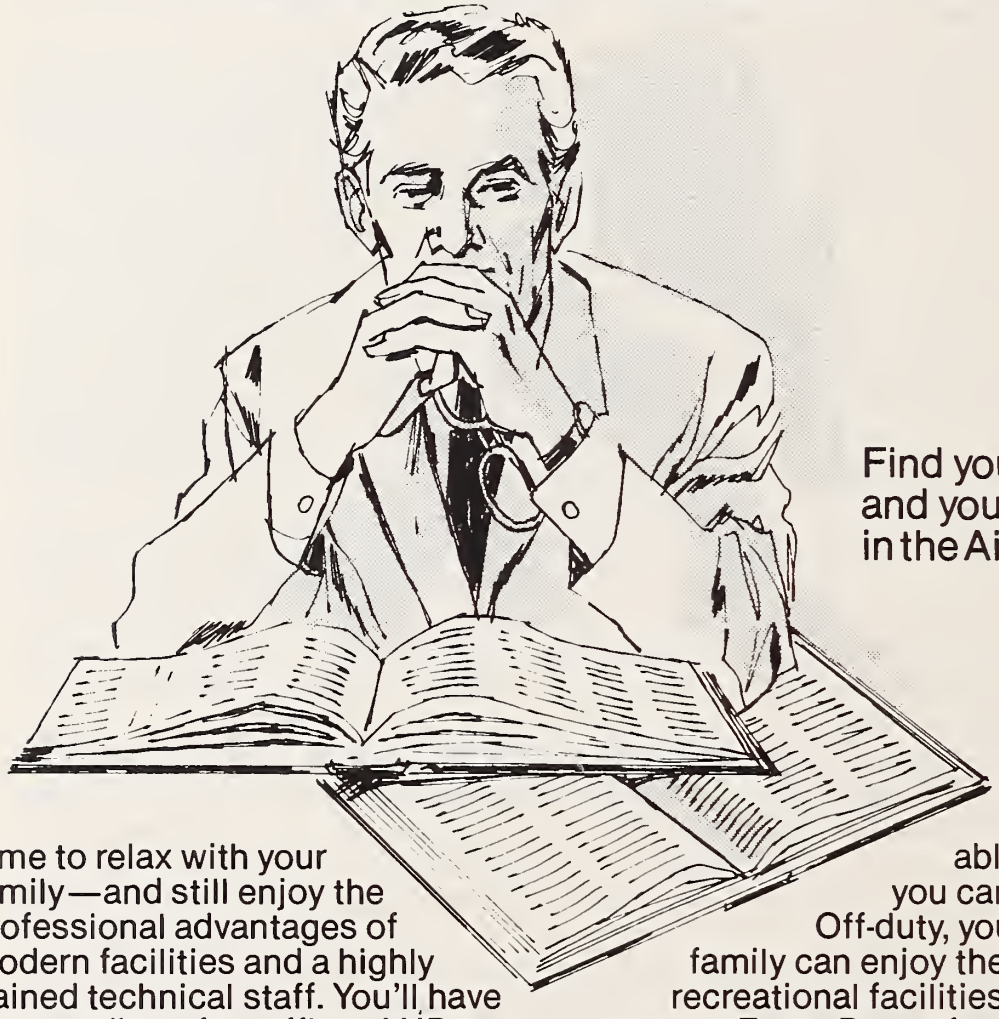
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Psychiatrist, Atlanta

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Genitourinary Tumors III: Cancer of the Testicle

SAM D. GRAHAM, JR., M.D., *Atlanta**

TESTICULAR TUMORS comprise 1% of all cancers occurring in males and are the most common solid tumors in males ages 20-40. These tumors, because of their high malignant potential, as well as the relatively young patients involved, have been one of the most intensively studied of all genitourinary cancers. The advent of Cis diaminodichloroplatinum (DDP) has remarkably affected the survival of patients with disseminated disease and has made testicular carcinoma one of the most successfully treatable of all genitourinary carcinomas.

The term testicular carcinoma actually incorporates several types of tumors, each with its own pathobiology, under one heading. In this paper, we will address the most common testicular tumors, germ cell tumors, and only mention the others for completeness. These include interstitial tumors such as Leydig and/or Sertoli cell tumors and tumors of the testicular tunica and adnexae such as mesotheliomas and sarcomas. Germ cell tumors comprise 90-95% of all reported testicular tumors and can be of a single cell type or a mixture of several types. Most schemata of the progenitors of germ cell tumors list a stem cell giving rise to either seminoma or nonseminomatous elements. The latter include embryonal carcinoma which can differentiate into either somatic (teratoma) or trophoblastic (choriocarcinoma) elements.

Etiology

The etiology of testicular tumors is not clear, yet certain conditions are associated with an increased incidence of testicular cancer. Cryptorchism has as much as a 40-times higher incidence of testicular tumor associated with it versus the normal population. Only early orchiopexy (at the age of 10 or less) may prevent the development of a tumor, and any intra-abdominal or high inguinal testicle which cannot be satisfactorily corrected surgically should probably be removed. Interestingly, patients with unilateral cryptorchism usually show dysgenesis not only of the maldescended testicle, but also in the normal contralateral testicle. This normal testicle is at higher risk for testicular tumor (approximately one out of five tumors associated with maldescent are in the contralateral normal testicle). Testicular atrophy, particularly mumps orchitis, is associated with a slightly higher incidence of testicular tumor. Other suspected etiology include trauma, exposure to toxins, and prenatal maternal hormonal exposure. Testicular tumors are far more common in whites than blacks.

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Clinical Presentation

The presenting symptom of a testicular tumor is usually a mass in the testicle discovered incidentally. Occasionally, the mass may be associated with a dull ache, rapid enlargement, acute hydrocele, or hemoscrotum following relatively insignificant trauma. Physical examination of a male with a testicular mass should include a routine examination of the chest, abdomen, and supraclavicular nodes for evidence of metastatic disease. The testicle in question should be examined in both the supine and upright positions to rule out varicocele. Palpation of the testicle should delineate the testicular size and consistency relative to the contralateral testicle, as well as delineation of the mass as either testicular or epididymal. Hydroceles accompany 5-10% of testicular tumors, such that transillumination may be required. Any male with a testicular mass of relatively sudden onset which is not associated with pyuria or voiding symptoms should be suspected of having a testicular tumor. The differential diagnosis includes torsion of the testicle and thus early exploration through an inguinal incision is recommended for any testicular mass which is in the least bit ambiguous. The indicated procedure is inguinal exploration with early vascular control of the cord. A trans-scrotal exploration in the presence of an ambiguous testicular mass is both contraindicated and will adversely affect the patient's prognosis if carcinoma is found.

If a patient is suspected of having a testicular tumor, preoperative work up should include a chest x-ray and serum protein markers for staging. Currently, the two best serum markers are beta-human chorionic gonadotrophin (bHCG) produced by the syncytiotrophoblast and alpha fetoprotein (AFP) produced by yolk sac elements of embryonal carcinoma. The half life of bHCG is 16 hours and AFP is 5 days, such that persistent postoperative elevation of these markers may be misinterpreted as residual disease if insufficient time is allowed prior to reassessment of the markers. bHCG may be elevated in all germ cell tumors, but AFP is never elevated in pure seminoma.

Most patients presenting with testicular tumors are Stage I. The nodal drainage of the testicle is along the spermatic vessels, thus positive nodes are usually first found near the renal hilum. If, however, the patient has had previous inguinal or scrotal surgery, then the lymphatic drainage has been interrupted, and the lymphatic drainage is to the femoral and external iliac nodes.

Once the pathologic diagnosis of testicular carcinoma is made, the patient undergoes staging of his disease. This includes reassessment of the marker proteins and CT scanning. Occasionally, intravenous pyelograms are still used as staging modalities. Pure seminomas, depending on the stage, usually are treated conservatively with good results, but nonseminomatous tumors, or seminomas associated with nonseminomatous elements, are treated more aggressively. Furthermore, if the patient has had a previous scrotal incision or scrotal orchiectomy, then in addition to the usual therapeutic recommendation, one should excise the affected hemiscrotum in combination with an *en bloc* dissection of the inguinal, femoral, and iliac nodes.

Seminoma

Seminoma is generally felt to represent a different progeny of the totipotential germ cell than the other types of testicular tumors. There are three types of seminoma: pure seminoma, spermatocytic seminoma, and anaplastic seminoma. Seventy-five to ninety per cent of all seminomas will be Stage I at presentation. Anaplastic seminomas, however, usually are detected at a later stage and thus are thought to carry a poorer prognosis. Comparison of classic to anaplastic seminoma stage for stage, however, reveals no difference in survival. Seminoma is thought to be radiosensitive and as such, the treatment of these tumors is surgical excision of the primary followed by staging of the tumor (CT scan, presence or absence of serum markers). Any elevation of AFP despite a pathologic diagnosis of pure seminoma in the primary should alert the clinician to the presence of other germ cell elements. Most groups treat pure Stage I seminomas by excision of the primary

followed by 2500 to 3000 rads to the para-aortic and ipsilateral pelvic nodes. This therapeutic approach has an excellent survival rate (99%) with minimal and controllable relapses (3.3%).

Metastatic seminoma is treated according to the bulk of disease, but generally involves radiotherapy. Stage II-A and II-B are treated with a wider field of radiotherapy but usually not above the mediastinum. Approximately 20-25% of these patients will develop mediastinal progression post radiation of the abdomen, yet these can be controlled with chemotherapy. Widespread and bulky disease is probably best treated with chemotherapy. Some groups advocate the standard platinum containing regimens for these patients, but others point to equivalent success in seminomas without platinum.

Nonseminomatous Germ Cell Tumors

Nonseminomatous germ cell tumors include elements of embryonal, teratoma, and/or choriocarcinoma. A combination of embryonal and teratoma is also known as teratocarcinoma. Embryonal cell and teratoma spread primarily to lymphatics, while choriocarcinoma is frequently spread hematogenously.

Treatment of nonseminomatous germ cell tumors is more aggressive based on the observed enhanced malignant potential of these tumors. Stage I tumors (no clinically or radiographically evident retroperitoneal or chest adenopathy, normalization of serum markers) are treated by retroperitoneal lymphadenectomy for both pathologic staging and therapy. Stage II and Stage III tumors are treated with platinum based multiagent chemotherapy for cytoreduction, followed by retroperitoneal lymphadenectomy. The effect of the preoperative chemotherapy in these patients is frequently alteration of the histopathology to cystic mature teratomas. These masses expand and though pathologically benign, may progress in size to cause significant morbidity. Furthermore, recent data indicate that up to 27% of these patients may have residual carcinoma.

Chemotherapy for germ cell tumors, which comprise 90-95% of all reported testicular tumors, has dramatically improved the expected survival.

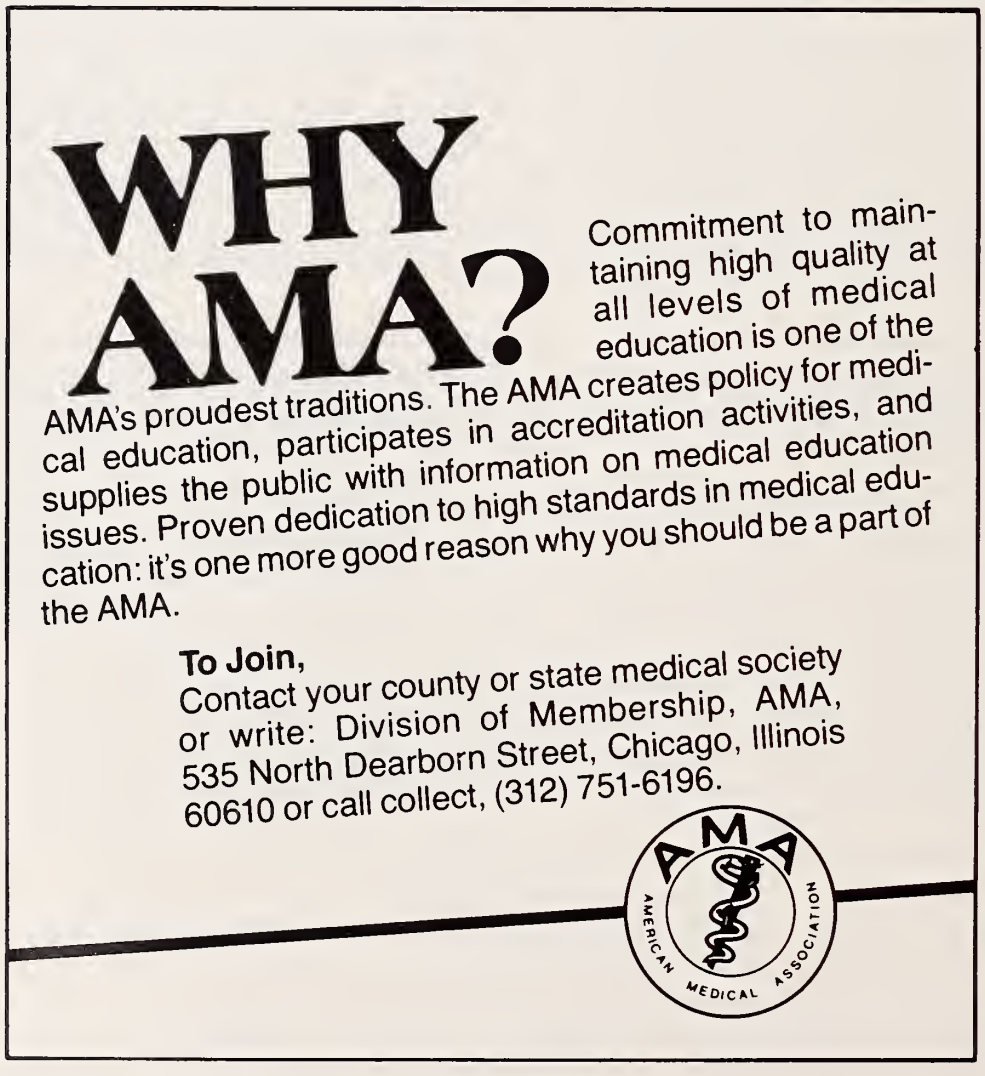
Controversy surrounds the retroperitoneal lymphadenectomy in regards to both the extent of the dissection and the actual impact on the tumor prognosis. There is considerable morbidity associated with the procedure as attendant to any transperitoneal procedure. However, in the patient population involved (young men in their reproductive prime), dissection along the great vessels interrupts the autonomic nervous system with side effects including retrograde ejaculation, anejaculation, and impotence. Furthermore, routine ligation of the branches of the aorta, lumbars, and inferior mesenteric arteries has been occasionally associated with spinal cord and colonic ischemia, respectively. Attempts to limit the dissection to reduce these side effects have been at least partly successful. However, there remains the criticism that this is an inadequate cancer operation due to the remaining lymph nodes. With the newer effective chemotherapy regimens, the pendulum appears to be swinging to more conservative surgery.

The other technical consideration in retroperitoneal node dissection is the advisability of a suprahilar node dissection (above the renal hilum). Due to the direct connection at this level to the cisternal chylae, this dissection is probably not curative, yet may be diagnostic. The incidence of suprahilar disease in the absence of intrahilar disease, however, is rare.

Chemotherapy for germ cell tumors has dramatically improved the expected survival. Since testicular tumors are rapidly growing and highly malignant tumors, most patients surviving more than 2 years disease free can be considered cured. Prior to the advent of cis-DDP, patients with Stage I treated by surgery alone could expect 85% cure rates, while as the bulk of nodal disease increased, survival

decreased, being 60-80% with the microscopic retroperitoneal disease, and 20-60% with grossly positive nodes. With cis-DDP based multiagent chemotherapy, patients with Stage II and III disease, treated when progression was evident, experienced > 98% (54/55) complete remission rate. Current recommendation for patients with testicular carcinoma is no adjuvant chemotherapy for Stage I or II disease. When disease progression is noted, by either follow-up serum markers, CT scan or chest x-ray, then chemotherapy is instituted. Preoperative bulky retroperitoneal disease is treated with preoperative chemotherapy followed by retroperitoneal node dissection.

Clearly, testicular carcinomas are a potentially devastating disease due to their highly malignant nature in a patient population of young, healthy adults. However, advances in chemotherapy as an adjunct to surgical staging have made this disease far more manageable.



Georgia Supreme Court Invalidates Involuntary Sterilization Statute

THOMAS D. HARPER, *Atlanta**

THE GENERAL THEORY of "eugenics" — that society may be improved through selective breeding — has enjoyed a long popularity, premised in part upon the nearly universal agreement that certain defective traits should be avoided for the general public good. For centuries there has been a general consensus that, at the least, society is justified in protecting itself by eliminating the reproductive capabilities of the defective persons. This rationale has been carried to dangerous extremes in a number of well-known cases: In ancient Greece, the Spartans permitted their sickly to die rather than become a burden upon society. In Nazi Germany, a program of enforced sterilization based upon racial philosophies led to the implementation of the German Sterilization Law of 1933 which sanctioned approximately 225,000 operations by 1937.[1]

Despite these and other abuses, eugenic theories are the foundation for statutes throughout the United States. The greater concern for individual rights which has long been the hallmark of this nation, however, has resulted generally in identification of a far narrower class of "defectives" and in greater protection of the members of that class. Specifically, the concept of improving society through genetics has been limited in this country to restrictions upon the reproductive capabilities of criminals and the mentally defective. Moreover, the rights of the persons subject to this proscription have been enhanced by the recent judicial recognition of procreation as a fundamental right. As a result, any limitation upon the reproductive ability of a person, as with any limitation upon any other fundamental right of individual liberty, is subjected to a stringent standard of judicial review.

Application of this enhanced standard recently resulted in the judicial rejection by the Georgia Supreme Court of Georgia's foray into genetic engineering, O.C.G.A. §31-20-3. This interesting case is the subject of this month's Legal Page.

Background

Although the recent trend within the United States has been towards a rejection of state-approved genetic control, the United States Supreme Court's first review of the matter resulted in its upholding a Virginia statute which authorized the sterilization of mentally defective persons.[2] In that case, the Court summarily rejected a challenge to the statute premised upon an alleged violation of the individual's constitutional right to due process:

* Prepared at the request of the Medical Association of Georgia. Mr. Harper is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve with their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. . . . Three generations of imbeciles are enough.

Buck v. Bell, supra, 274 U.S. at 207 (citations omitted). Thus, the United States Supreme Court rejected a substantive challenge to a sterilization statute by recognizing that sterilization is not invariably prohibited by the Constitution.

Subsequent constitutional attacks on state-authorized genetic engineering have enjoyed a greater success by focusing upon the *procedures* for determining which persons should not have the ability to bear children, rather than on the *substance* of the statutes. For example, constitutional challenges have been mounted on contentions that sterilization statutes constituted cruel or unusual punishment, a violation of the Equal Protection clause, an unlawful delegation of legislative or judicial powers, a bill of attainder, or a violation of the right to life, liberty, and the pursuit of happiness.[3] These arguments have met with varying degrees of success, but they have generally resulted in a reduction in the number of state-mandated sterilizations.[4]

In 1970, the State of Georgia initiated its eugenic program by authorizing the sterilization of mentally incompetent persons.[5] This statute provided for the sterilization of a person who, because of mental retardation, brain damage, or both, is incurably mentally incompetent to the degree that such person could not provide for the care and support of any children. Sterilization could be secured by a petition filed with the probate court of the county of residence of the alleged mental defective by one or more of several persons: the parents or legal guardian or next of kin of the mentally defective person; the Commissioner of the Georgia Department of Human Resources; or the Director of the appropriate county board of health or department of family and children services. After an examination of the subject by two physicians appointed by the judge of the probate court (neither of whom is the physician intending to perform the sterilization), a report is submitted and a hearing conducted. Upon a finding, by a "legal preponderance of all the evidence," that sterilization is appropriate under the statute, the probate judge enters an order authorizing the performance of the sterilization under procedures approved by a committee of physicians from an accredited hospital. Thereafter, any interested party can appeal the probate judge's order to the Superior Court, which is authorized to hear the appeal and to consider all evidence necessary for an independent determination of the propriety of sterilization. In turn, this decision may be appealed to the Georgia Supreme Court.

The Georgia Supreme Court's Decision

In *Motes v. Hall County Department of Family and Children Services,*[6] the Hall County Department of Family and Children Services utilized these procedures and obtained an order for the sterilization of Ms. Motes, a 21-year-old retarded woman. Ms. Motes, through counsel, challenged this determination and the statute upon which it was based as being in violation of her constitutional rights to due process and equal protection. The focus of her appeal was the contention that the sterilization would constitute an invasion of her fundamental personal rights and thus required the State to prove the necessity of the procedure by more than a simple "preponderance of the evidence." The Supreme Court agreed and held the statute to be unconstitutional.

As a general proposition, the burden of proof which a party must bear in order to secure judicial authorization for a selected course of action varies with the societal interest in the outcome of the judicial action. The "preponderance of the evidence"

standard is indicative of society's "minimal concern with the outcome and a conclusion that the litigants should share the risk of error in a roughly equal fashion." This is the standard which is applied in litigation between private citizens. When the state or federal government is seeking judicial relief, however, a heavier burden is applied. The standard of "clear and convincing evidence" is appropriate when the individual interest at stake in a state proceeding is both "particularly important" and more substantial than the "mere loss of money." The most stringent standard, "beyond a reasonable doubt," demonstrates the "weight and gravity of the private right affected, society's interest in avoiding an erroneous conviction, and a judgment that those interests together require that society impose upon itself almost the entire risk of error."[7]

Applying these general principles, the Supreme Court of Georgia held in *Motes* that a termination of the ability to reproduce must be subject to at least a standard of "clear and convincing evidence." The Court reviewed a long line of authority establishing that freedom of personal choice in matters of family life is a fundamental liberty protected by the Fourteenth Amendment. Further, the Court recognized an inherent inconsistency in statutory procedures which permitted the termination of parental rights to keep and raise children only upon proof of "clear and convincing evidence,"[8] but authorized the termination of the ability to ever bear children upon a mere "preponderance of the evidence" showing. Thus, the Court struck down the statutory procedure for involuntary sterilization.[9]

In summary, the Georgia Supreme Court in the *Motes* case was merely following the lead of the United States Supreme Court in the recognition that the more important the personal right which is being invaded, the heavier the burden of proof the state must bear to justify an intrusion. The Court's decision in no way undermines the proposition that a state may, under appropriate circumstances, terminate the right of a parent to bear children. The Georgia Supreme Court merely recognized that an intrusion upon so fundamental a right as the ability to bear children requires proof by the state of at least a "clear and convincing" necessity for such an act.

The Supreme Court's action in *Motes* came notwithstanding the fact that the Superior Court had recognized the constitutional deficiency of the statute and had applied the correct standard. The Supreme Court held that judicial action could not redeem the legislative omission of the proper burden of proof and negated both the sterilization order and the statute upon which is was based. Thus, at least until the Georgia General Assembly enacts a new statute, there is no statutory procedure in Georgia whereby mental incompetents may be sterilized against their will.

Notes

1. See Comment, "Sterilization: A Continuing Controversy," U. San Francisco L. Rev. 159 (1966), cited in Anno., 53 A.L.R. 3d 960, 963 n. 12 (1973).

2. *Buck v. Bell,* 274 U.S. 200 (1927).

3. Anno., 53 A.L.R.3d 960 (1973). See, for example, *Skinner v. Oklahoma,* 316 U.S. 535 (1942) (compulsory sterilization of thrice convicted inmate a violation of Equal Protection Clause because of an invalid statutory distinction between a conviction for larceny — which justified sterilization — and embezzlement — which did not).

4. An additional factor in this limitation of sterilization is the recognition that it is largely ineffective in eliminating defective genes. See, Matoush, "Eugenic Sterilization — A Scientific Analysis," 46 Denver LJ 631 (1969).

5. O.C.G.A. §31-20-3, formerly Ga. Code Ann. §84-933. This statute did not suffer from overuse. Although no statewide statistics are available, it appears that only three petitions for involuntary sterilization were filed in Fulton County in the past five years. See, *The Atlanta Journal,* September 9, 1983 at 2-C.

6. No. 39923 (Sept. 7, 1983).

7. *Santosky v. Kramer,* 455 U.S. 745, 755-56 (1982); *Addington v. Texas,* 441 U.S. 418, 423-25 (1979).

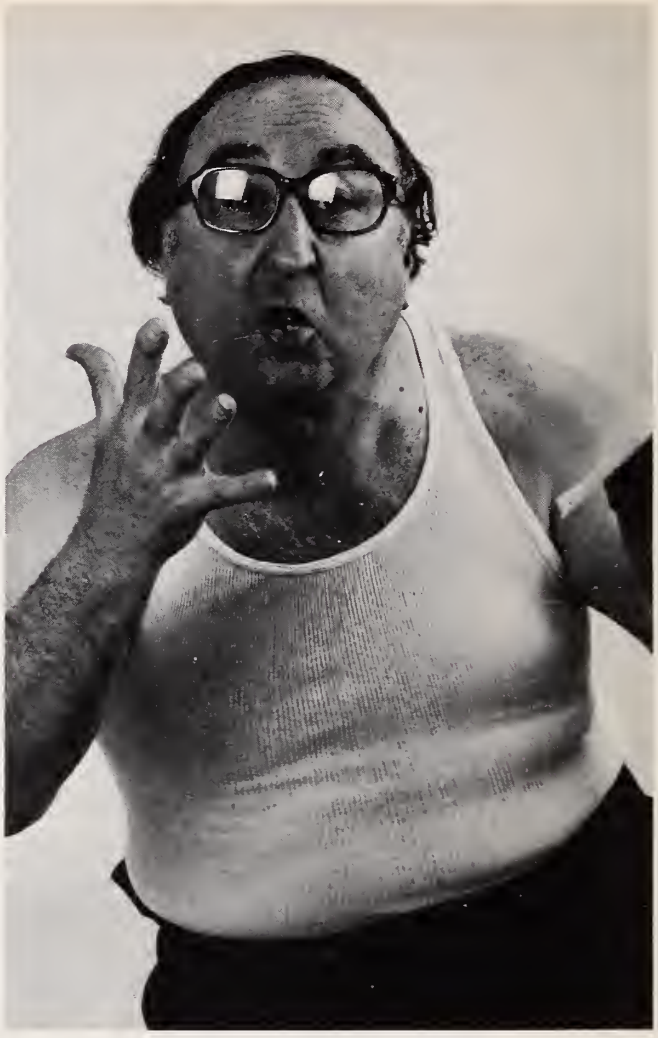
8. O.C.G.A. §15-11-33, formerly Ga. Code Ann. §24A-2201. See, *Nix v. Department of Human Resources,* 236 Ga. 794, 795, 225 S.E.2d 306 (1976); *Brown v. Department of Human Resources,* 157 Ga. App. 106, 108, 276 S.E.2d 155 (1981) (evidentiary standard is "compelling facts" which demonstrate the necessity for the termination of parental rights to raise their children).

9. The Court did not deal with O.C.G.A. §31-20-2, formerly Ga. Code Ann. §84-932, the statutory approval of sterilization procedures performed by a physician *upon request* by a person 18 years of age or older. O.C.G.A. *31-20-2 provides that:

> It shall be lawful for any physician acting in collaboration or consultation with at least one other physician to perform a sterilization procedure upon a person 18 years of age or over, or less than 18 years of age if legally married, provided that a request in writing is made by such person and by his or her spouse if married and such spouse can be found after reasonable effort and provided, further, that prior to or at the time of such request a full and reasonable medical explanation is given by such physician to such person as to the meaning and consequence of such operation.

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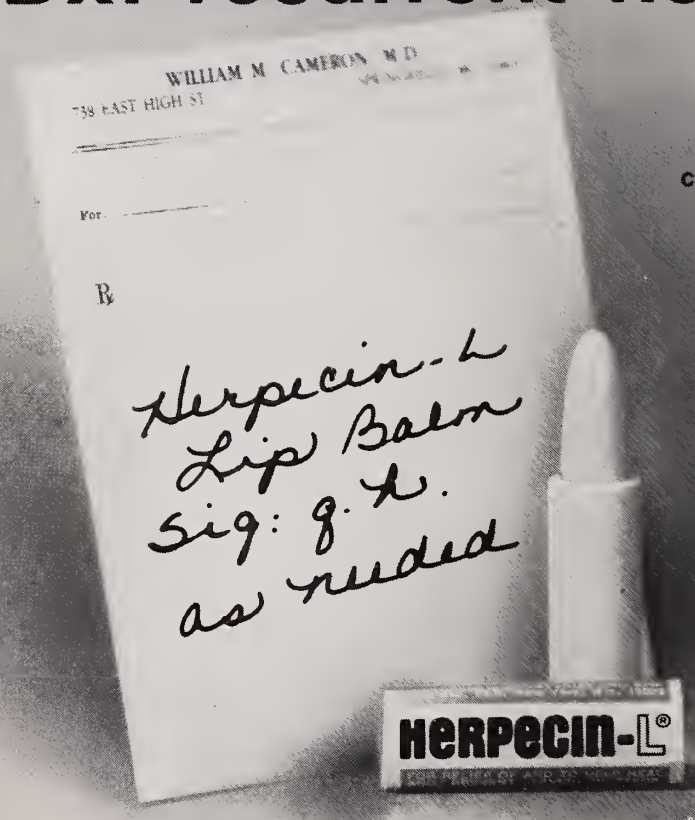
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Ventricular Premature Beats: What Risk Do They Imply?

RICHARD R. WHITLOCK, JR., M.D., *Augusta**

THE TWO MAJOR CONSIDERATIONS in the decision of whether or not to treat ventricular premature beats (VPBs) are (1) the symptoms they cause and (2) the threat they pose. This paper will review data on the latter, that is, the risk conferred by the presence of VPBs. Most of the available data suggests that VPBs in normal persons, particularly young persons, are not associated with an adverse prognosis and therefore do not require therapy unless they cause symptoms. Many of the pertinent studies concerning risk of sudden death associated with serious arrhythmias are reviewed here.

Kluger and Hinkle[1] evaluated VPBs in asymptomatic ambulatory individuals with and without clinical heart disease. Frequent VPBs were arbitrarily defined as more than 10 VPBs per 1000 heart beats. The incidence of arrhythmic death was higher among those with frequent VPBs than those with none. The presence of more than 10 VPBs per 1000 heart beats in association with clinical evidence of ischemic heart disease was associated with a sudden death rate of 28% in 5 years, compared with 8% when clinical evidence of ischemic heart disease was not present.

Rabkin et al[2] evaluated routine electrocardiograms (EKGs) in men without apparent heart disease at entry and predominantly between ages 25 and 34 years. The total number of persons observed was 3,983 over 29 years. Four hundred and one persons were found to have VPBs at a routine exam. After entry, the patients were followed up by annual mail contact, with medical examinations and EKGs at 3-5 year intervals. Sudden death was the clinical manifestation with the strongest association with VPBs.

Kotler et al[3] evaluated 12-hour EKG recordings in 160 male survivors of acute myocardial infarction (AMI), all under 65 years of age and in the New York Heart Association Class I or II. VPBs were detected on at least one recording in 80%. Fourteen sudden cardiac deaths were noted during 30 to 54 months follow up. Twelve of the 14 occurred in 87 patients (13.8%) with significant VPBs. Frequent, unifocal VPBs, multifocal VPBs, couplets, and ventricular tachycardia (VT) were regarded as significant. VPBs were defined as frequent if more than 10 were detected per hour. Ventricular parasystole was recognized in 27 of the 160 patients, but was not predictive of sudden cardiac death.

Moss et al[4] evaluated 272 patients under age 65 who were followed for 1 year after AMI. Six-hour ambulatory EKG recordings were obtained before hospital

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discharge and 5 months after discharge. VPBs at rates of 20 or more per hour recorded before discharge were associated with the occurrence of complex VPBs, and with an increased cardiac mortality in the initial 0 to 4 months after discharge, but not in the subsequent 8 months. VPBs recorded 5 months after discharge were not associated with increased cardiac mortality in the subsequent 5 to 12 months.

Vismara et al[5] evaluated arrhythmias during the entire 3-week hospital period following AMI in 83 patients. They found that the absence of VPBs including serious complex forms and VT in the Coronary Care Unit (CCU) did not exclude a high incidence of such arrhythmias in the late hospital phase. VPBs, particularly complex forms, had prognostic significance relative to sudden death after discharge. VPBs were classified as complex if they were multiform, paired, or R on T, or had a frequency of 5 or more per minute. The occurrence of VPBs in the CCU after acute infarction, including VT and VF, was not predictive of sudden death after hospital discharge. Complex arrhythmias that occur in the CCU following AMI may be of limited duration and therefore do not identify those patients prone to sudden death after hospital discharge. However, ventricular arrhythmias detected with Holter monitoring just prior to hospital discharge after AMI correlated significantly with sudden death after discharge. The patients who died suddenly had an increased prevalence of complex VPBs as compared to those who survived (67% vs 34%).

Schultz et al[6] demonstrated that higher grades of ventricular arrhythmias are associated with more extensive myocardial infarction. All sudden deaths during 1-year follow-up period occurred in patients who had ejection fractions under 40% *and* had complex VPBs on Holter monitoring. Those patients who had left ventricular ejection fractions greater than 40% survived, even if VPBs were present. Those who had poor left ventricular function without complex VPBs also survived.

It appears that the strongest association with increased mortality is with ventricular tachycardia, and the evidence that increased mortality is associated with other forms of complex ventricular premature beats is less impressive.

Resting EKGs of 2,035 AMI survivors were examined in the Coronary Drug Project.[7] During the 3-year follow-up period, death was twice as frequent among those with VPBs. An increased risk of sudden death was associated with frequent VPBs, repetitive VPBs, and early cycle VPBs independent of 28 other risk factors.

The Rochester Post Infarction Program Study[8] classified patients according to the presence of low risk VPBs (late cycle and/or unifocal, regardless of frequency) and high risk VPBs (early cycle and/or multiform). Low-risk VPBs conferred a 2-year mortality risk of 10%, whereas patients with high-risk VPBs had a 2-year mortality risk of 20%.

Ruberman and Weinblatt[9] evaluated 1,739 male survivors of AMI who were enrolled in the Health Insurance Plan of Greater New York. This study involved 1 baseline hour of ambulatory EKG monitoring and repeated monitoring at 6-month intervals for a maximum of four recordings. Men demonstrating complex VPBs (runs of two or more, R on T, bigeminy, or multiform beats) on the baseline monitoring hour were found to have an elevated mortality risk over an average of 3½ years (2-5.5 years). Over this period, the probability of sudden death was 18% for men with complex VPBs and 8% in the other men. For repetitive VPBs or R-on-T VPBs during the baseline period of monitoring, the probability of sudden death was 25%, but only 13% in men with other complex VPBs. The probability of sudden death in men with simple VPBs only was 12%, and 6% if no VPBs were seen during the hour.

Bigger and associates[10] evaluated 428 patients with 24-hour ambulatory monitoring performed 10-20 days after admission to the hospital for AMI. Of the 428 patients studied, 50 (11.6%) had VT. The frequency of VPBs was markedly higher for patients with VT than for those without. Also, complex forms (bigeminy,

paired, multiform VPBs, and the R-on-T phenomenon) occurred more often in the patients with VT. At 1 year, the overall mortality rate in those without VT was 11.6%, but was 38% among 50 patients with VT.

The same authors[11] later reported similar findings in 430 patients who survived for at least 2 weeks following AMI and were studied for at least 1 year. On Holter monitor, high VPB frequency was associated with an increased risk of dying. Twenty-six percent of the patients had 10 or more VPBs per hour and were 2.6 times as likely to die within a year as those with fewer VPBs. Thirty-one percent had repetitive VPBs, and these patients were 3.2 times as likely to die as those without repetitive forms. There was a significant association of 1-year mortality with frequent or repetitive VPBs which appeared to be independent of other risk factors. Frequent or repetitive VPBs were reported to exert a mortality force over and above that of left ventricular dysfunction. Patients who were discharged using digitalis were 4.5 times as likely to die within a year as the patients who were not treated. Digitalis ranked third after VPB frequency in the strength of association with mortality of 1 year. However, subsequent studies have shown that digitalis use is strongly associated with left ventricular dysfunction.[12] This suggests that it is not an independent contributor to mortality.

Spielberg and associates[13] found that 27 of 101 patients with complex VPBs (couplets, bigeminy, and VT) on 24-hour Holter monitoring died during a mean follow up of 12 months. Mortality was 43% when ventricular tachycardia had been detected. Bigeminy had no prognostic significance and ventricular couplets had little significance. This study did not include patients in the first year following AMI. However, the prognosis was significantly worse in patients with a history of less recent MI. The prognosis of complex VPBs was significantly worse in older patients. There appeared to be little prognostic significance of complex VPBs in patients under the age of 60.

Conclusion

The bulk of the evidence supports a conclusion that frequent and complex VPBs are associated with an increased mortality risk in persons with ischemic heart disease, especially if left ventricular dysfunction is also present. However, it appears that the strongest association with increased mortality is with ventricular tachycardia, and the evidence that increased mortality is associated with other forms of complex VPBs is less impressive. A subsequent paper will address the issue of prevention of sudden death with treatment of VPBs.

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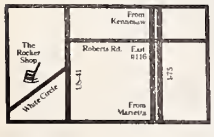
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700 Oglethorpe Ave., Athens 30606

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PERSONALS

Second District

Joseph Murray Turner, M.D., of Tifton, has been elected to Fellowship in the American College of Physicians.

Fifth District

William W. Moore, Jr., M.D., Atlanta neurosurgeon and President of the MAG, was installed as Chairman of the Council of the Southern Medical Association at its 77th Annual Scientific Assembly in Baltimore, November 6-9. Dr. Moore is also a delegate to AMA from Georgia and is Clinical Professor of Surgery (Neurosurgery) at Emory University School of Medicine.

Atlanta physician, **William M. Lester, M.D.,** has been elected to the Board of Directors of Blue Cross and Blue Shield of Georgia/Atlanta.

Eugene L. Crews, III, M.D., has been named Director of the Adult Treatment Program at Brawner Psychiatric Institute, Smyrna.

Sixth District

The son of **J. Morgan Kellum, M.D.,** John Kellum, M.D., of Thomaston, has resigned his position as associate professor, general surgery, Tufts University School of Medicine — New England Medical Center, Boston, and moved to Richmond, VA, where he will be full professor of general surgery. Dr. Kellum was recently a guest speaker at medical seminars in Vienna, Austria, and Montreux, Switzerland.

Seventh District

Charles H. Herndon, M.D., an orthopaedic surgeon formerly of Dalton, has moved his practice to Griffin.

Ninth District

Robert A. Burns, M.D., general surgeon, has joined the practice of Willard P. Carson, M.D., of Dalton. Dr. Burns has been appointed a member of the active medical staff of Hamilton Medical Center.

DEATHS

James T. Lowe, Jr., M.D.

James T. Lowe, Jr., M.D., of Macon was killed September 18 when his light plane crashed during takeoff. Dr. Lowe was 40. He was an ear, nose, and throat specialist. Dr. Lowe was a graduate of Mercer University and the Medical College of Georgia. He was on the Board of Directors at Colliseum Park Hospital.

Survivors include his wife, four children, his parents, and two brothers.

Voris Francis McFall, M.D.

Voris Francis McFall, M.D., 68, died September 13, at his home in Fort Valley. Dr. McFall was a graduate of Indiana University School of Medicine and served his internship at Ball Memorial Hospital in Muncie, Indiana. In the U.S. Air Force, he completed a 3-year residency in surgery at Walter Reed General Hospital in Washington, D.C. He was commander of several Air Force hospitals worldwide. A Fellow of the American College of Surgeons and a member of the Aero-Medical Association, Dr. McFall retired as hospital commander from Robins Air Force Base in 1962.

Dr. McFall is survived by his wife, two sons, one daughter, and four grandchildren.

Loree Florence, M.D.

Loree Florence, M.D., an Athens pediatrician, died September 23, at the age of 87. Dr. Florence was the first woman graduate of the Medical College of Georgia. She was a physical fitness enthusiast and because of her swimming exploits, was once featured in *Sports Illustrated* magazine. She was active in Crawford W. Long County

Medical Society and the Elijah Clarke Chapter of the Daughters of the American Revolution and taught at Shorter College. A native of Washington, she was the widow of Moses Bernstein.

Survivors include two nephews.

C. J. Roper, M.D.

Jasper physician, C. J. Roper, M.D., died September 19. He opened his office in Jasper in 1935 and in 1940 built Pickens County's first hospital. He served as a Flight Surgeon during World War II and also served a term in the Georgia Senate in the late 1950s. Dr. Roper was a member of the International College of Surgeons, a member of the Shrine Club, a charter member of the Jasper Lions Club, and a member of the First Baptist Church of Jasper. According to Jasper's newspaper, *The Pickens County Progress,* "Pickens County has lost one of her most respected and honored citizens.

Dr. Roper is survived by his wife of 51 years, three daughters, two brothers, and two sisters.

Robert J. Ross, M.D.

Robert J. Ross, M.D., aged 38, was killed in an automobile accident on October 13. He was the nephew of Jack K. Bleich, M.D., of Atlanta. Dr. Ross graduated from Emory University School of medicine and completed his residency in OB/GYN at Grady Memorial Hospital in Atlanta in 1980. He established his practice in Eden, North Carolina.

He is survived by his wife, the former Linda Terry, a graduate of Georgia State University Nursing School.

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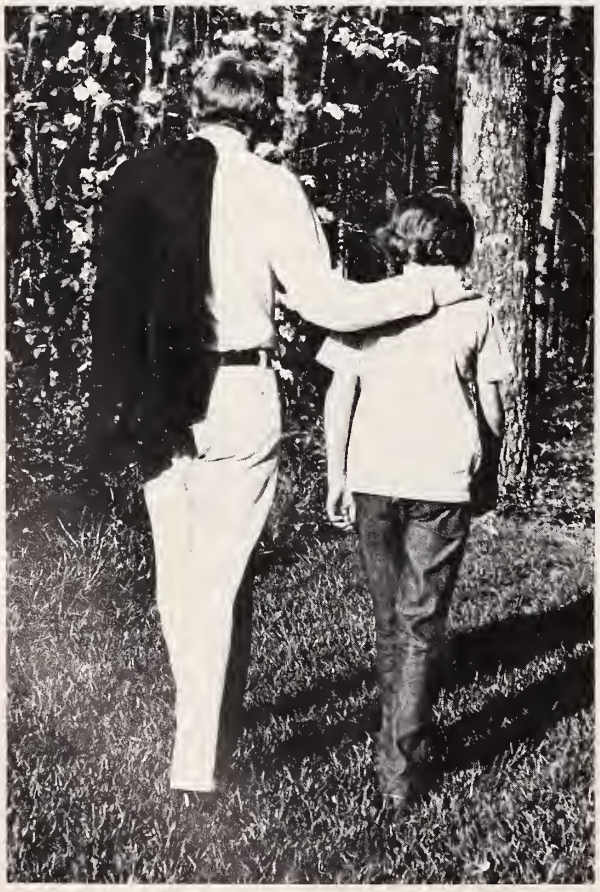
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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from July through September, 1983.*

The Award was established in 1969 "to recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored for Category I credit by organizations accredited for these activities.

The MAG House of Delegates has set a goal that all MAG members shall have received the PRA by 1985. We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Vergil R. Abreu, Millen
Rodolfo R. Agraz, Smyrna
Barbara Allen-Dalrymple, Commerce
Teofredo C. Aranas, Columbus
Thomas S. Arnold, Augusta*
William H. Benson, Smyrna
Edward W. Berg, Augusta
Joseph L. Berg, Albany
Robert B. Berkowitz, Marietta*
C. Markham Berry, Atlanta
Luis C. Blanco, Milledgeville*
William F. Bloom, Macon
Otoniel M. Boudet, Milledgeville*
Gregory Bracewell, Grovetown*
Steven C. Brena, Decatur*
James A. Brigman, Atlanta
Betty S. Brooks, Augusta
Harold P. Brusman, Riverdale
David A. Burgess, Atlanta*
Robert T. Cain, Quitman
Raymond V. Caputo, Atlanta
Henry B. Carroll, Columbus
Henry R. C. Chalmers, Atlanta
Alice K. Graybill Chelton, Atlanta
Min-Haing Cho, Augusta*
David M. Cohen, Atlanta
Sheldon B. Cohen, Atlanta
George R. Conner, Columbus
John R. Cook, Ft. Gordon*
Jerry Lee Cooper, Decatur
Charlotte T. Cox, Macon
John L. Davis, Atlanta
Rekha J. Desai, Lawrenceville*
Eloy E. Diaz, Jonesboro*
Charles E. Drake, Savannah
Stephen K. DuRivage, Albany*
Loui D. Elfrink, Martinez*
Hossam E. Fadel, Augusta
Thomas E. Fulmer, Atlanta
Charlton B. Futch, Brunswick
Edward C. Gardner, Athens
Kevin F. Gibson, Riverdale*
Frederick E. Gilbert, Newnan
Chenault W. Hailey, Atlanta
John J. Haskin, Ft. Gordon*
Ralph L. Haynes, Atlanta
John M. Hemphill, Savannah
Richard S. Hoffer, Martinez*
Dirk E. Huttenbach, Marietta
John E. Imhoff, Brunswick
Eugene H. Jackson, Moultrie
Norman F. Jacobs, Decatur
Paul J. Jarrett, Decatur*
Gregory L. Jerkins, Atlanta*
Fleming L. Jolley, Brunswick
Hee Chang Jung, Riverdale
David B. Kee, Decatur*
William K. Kinlaw, Decatur
Alan D. Kirsh, Macon
Somanath G. Kudchadker, Columbus*
Donald M. Kurtz, Columbus
Omar M. Lattouf, Decatur*
Juan F. Leiva, Savannah*
Walter E. Limehouse, Atlanta
Harold G. Long, Dahlonega
Bettadapura R. Manjunath, Martinez*
Brenda L. Marino, Marietta*
David M. Martin, College Park*
William E. Mayher, Albany
Talbot G. McCormick, Decatur*
Howard C. McMahan, Washington*
William Miles, Augusta*
Donald J. Mirate, Valdosta
William E. Mitchell, Atlanta
Edmund M. Molnar, Columbus
Ellyn Z. Musser, Marietta
Jocelyn R. Neufeld, Athens
Hillery R. Newland, Athens
Richard W. Nysewander, Decatur
John F. O'Brien, Decatur
James G. Parke, Jekyll Island
Carol Ann Phillips, Augusta
Benjamin L. Pike, Savannah
Raul J. Pineyro, Milledgeville*
Robert D. Ranlett, Evans*
Albert P. Rauber, Atlanta
James L. Ray, Swainsboro
Rafael G. F. Razuri, Savannah*
A. Cullen Richardson, Atlanta
Deborah K. Richardson, Augusta*
John C. Rieser, Atlanta
Jose F. Rodriquez-Curras, St. Simons Island*
Stephen D. Rossner, Marietta
Stephen J. Rudolph, Douglas
Richard K. Rudy, Atlanta
Floyd R. Sanders, Decatur
Hugh W. Shackelford, Atlanta
Julius Sherwinter, Atlanta*
Forrest A. Smith, Atlanta*
Richard A. Smith, Atlanta
James P. Steinberg, Atlanta*
Shaw Cheng-Tsuau Su, Savannah
Julian W. Swann, Atlanta
Robert V. Tauxe, Atlanta*
Satyanarayana K. Tikare, Augusta*
Dexter T. Todmann, Atlanta
Rose C. Trincher, Augusta
Hasan M. Turgut, Milledgeville*
M. Darius Vohman, Atlanta
Bradley Lee Ward, Taylorsville*
Marion L. Weinstein, Atlanta*
Roger G. Wellborn, Macon
John H. West, Savannah
James Q. Whitaker, Warner Robins
Paul C. White, Albany
Dana F. Whyte, Atlanta
Clarence R. Wilcox, Rome
Howard J. Williams, Macon
Nilda B. Winiarski, Lithia Springs
Lee T. Woodall, Barnesville*
Robert K. Worman, Columbus
Stephen C. Wright, Atlanta*
Howard S. Yager, Atlanta
Henry W. Young, Cordele*
Sharon J. Youngleson, Atlanta

* Not a member of MAG as of 10/11/83.

Committee Activities . . .

Highlights — MAG Board of Directors, September, 1983

Operation Care — The Board voted to develop a modified version of the program for implementing after next January 1, when Operation Care as presently organized will cease to function.

Legislation — The Board considered a number of issues likely to appear in the 1984 Georgia General Assembly and took the following action:

—opposed creation of a new licensure board for the purpose of licensing radiologic technicians;
—favored introduction of an amendment to the Medical Practice Act which clearly states that physicians can delegate medical acts to non-licensed individuals for which the physician is both responsible and liable;
—voted that a raw score of 75 on the FLEX medical licensing examination be required of all applicants in Georgia, including veterans;
—went on record in support of H.B. 602, entitled "Rights of Deprived Children";
—directed that legislation should be sought to restrict the term *physician* in Georgia law to only those persons licensed by the Composite State Board of Medical Examiners;
—agreed that the MAG will not oppose Governor Harris' plan to require members of all state boards to serve only two full appointed terms.

Freestanding Emergency Clinics — The Board approved all of the recommendations of the MAG *Ad Hoc* Committee on Freestanding Emergency Clinics (FECs):

—that primary care physicians in a given locality should be urged to cooperate with their colleagues and keep their offices open after hours and on weekends on a rotating basis;
—that MAG should undertake a media campaign to promote the concept of traditional private practice;
—that county medical societies in areas with FECs should undertake media efforts adopted to their local needs;
—that MAG should provide a model plan or some other kind of technical assistance for the above campaign to county medical societies; and
—that MAG and county medical societies should actively recruit for membership physicians working in FECs.

Public Relations — The Board authorized the employment of a new MAG staff member to work exclusively in the area of public relations.

Cost Awareness — The Board recommended that local medicine/business coalitions should work cooperatively to address health insurance benefit design along with other issues relating to health costs.

High Blood Pressure Control — The Board endorsed the work of the Low-Cost Drugs Committee of the Georgia Statewide Coordination Plan for High Blood Pressure. The Committee's goal is to reduce individual financial barriers to obtaining medicine which treat hypertension.

Highlights of MAG's September Executive Committee Meeting

Committee on Legislation — The Chairman of the Committee on Legislation reported that a physician was bringing suit against the Composite State Board of Medical Examiners (CSBME) to keep it from informing hospitals and others of a disciplinary action taken against him. Discussion ensued relative to the dissemination of information on disciplinary actions taken by the CSBME. The Executive Committee (EC) voted that legal counsel advise it at the October meeting of means by which MAG might be able to involve itself in this matter in an effort to protect the public.

Membership Committee (Benefit Package) — at the August meeting, the Chairman of the Membership Committee submitted a membership benefit package which consisted of (1) members purchasing computer products from Select Systems; and (2) purchasing computer software designed for office management from MEDPAC. This matter was deferred to the September EC meeting in order that the members might study more closely this proposal. After discussion, the EC postponed further consideration of this matter.

Membership Insurance (Disability Income Program) — In August, the Executive Committee received a report from the Chairman of the Membership Insurance Committee and from representatives of the National Life Insurance Company of Vermont Disability Income Insurance. The EC deferred action on this report until the September meeting in order that information regarding this matter could be made available in writing to all EC members.

Representatives from World Service Life were present at the September meeting and spoke on behalf of the Southern Medical Association's Disability Income Insurance. Representative from National Life Insurance of Vermont were present to answer questions concerning their program. The EC referred the matter back to the Membership Insurance Committee for further investigations for these and other disability income insurance programs.

Maternal & Infant Health (M&I) Committee — At the August EC meeting, the chairman of the M&I Committee presented information regarding the infant mortality rate in Georgia. The EC deferred this matter to the September EC meeting and charged the chairman of the M&I Committee to head up a task force consisting of members of the M&I Committee, representatives of the OB/GYN, pediatric, and family practice specialties, and the DHR to formulate plans for improvement in this area. After discussion, the EC voted to implement two recommendations of the task force: (1) urge all counties and the state to

implement and fund the Medical Care For The Indigent Act; and (2) urge state funding of the DMA's proposal to expand coverage for the medically needy. In taking this action, the EC acknowledges the existence of the problem, demonstrates its concern and commitment, and assigns a high priority to developing an acceptable solution.

In another request, the M&I Committee requested approval of the EC to enlarge the task force to include representatives of the Georgia State Medical Society, the Georgia Hospital Association, legislators, and consumers. The EC approved contacting specific individuals asking them to serve on the task force.

The EC also discussed statewide and local cooperation between the public and private sectors in providing obstetric and infant follow-up care, with special emphasis on pregnancy and infants dealing with Medicaid.

Advisory Council to the Georgia Board of Nursing — The EC appointed Eugene O. Harrison, M.D., Atlanta general surgeon, as MAG's representative to this Council for a term from October, 1983, through September, 1986.

Appointment to Committee on Legislation — The EC appointed W. Scott James, M.D., Atlanta pediatrician, to serve as a member of the MAG Committee on Legislation, effective immediately.

Composite State Board of Medical Examiners Appointments — The EC discussed appointments to the Board and voted to write Governor Harris recommending the following as members of the Board: Robert E. Thompson, family practitioner of Toccoa, and Carson B. Burgstiner, OB/GYN of Savannah.

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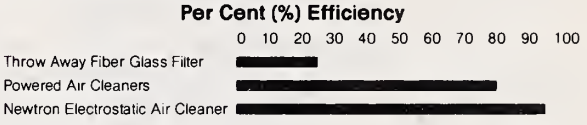
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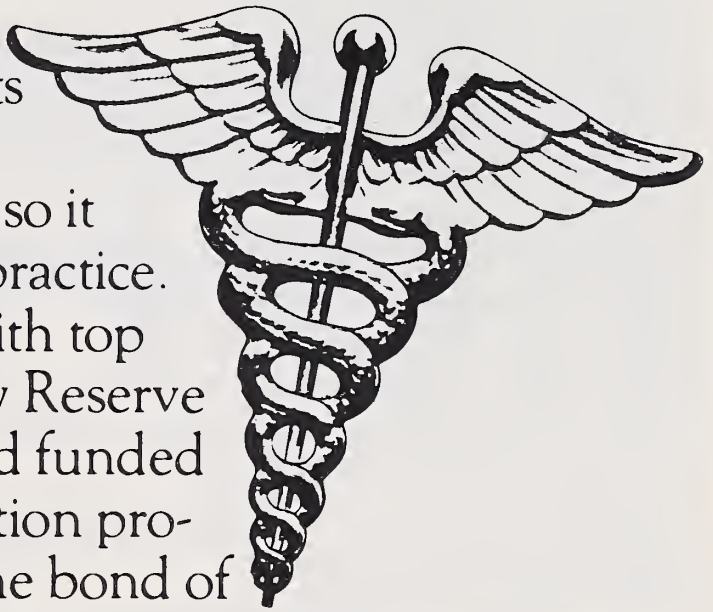
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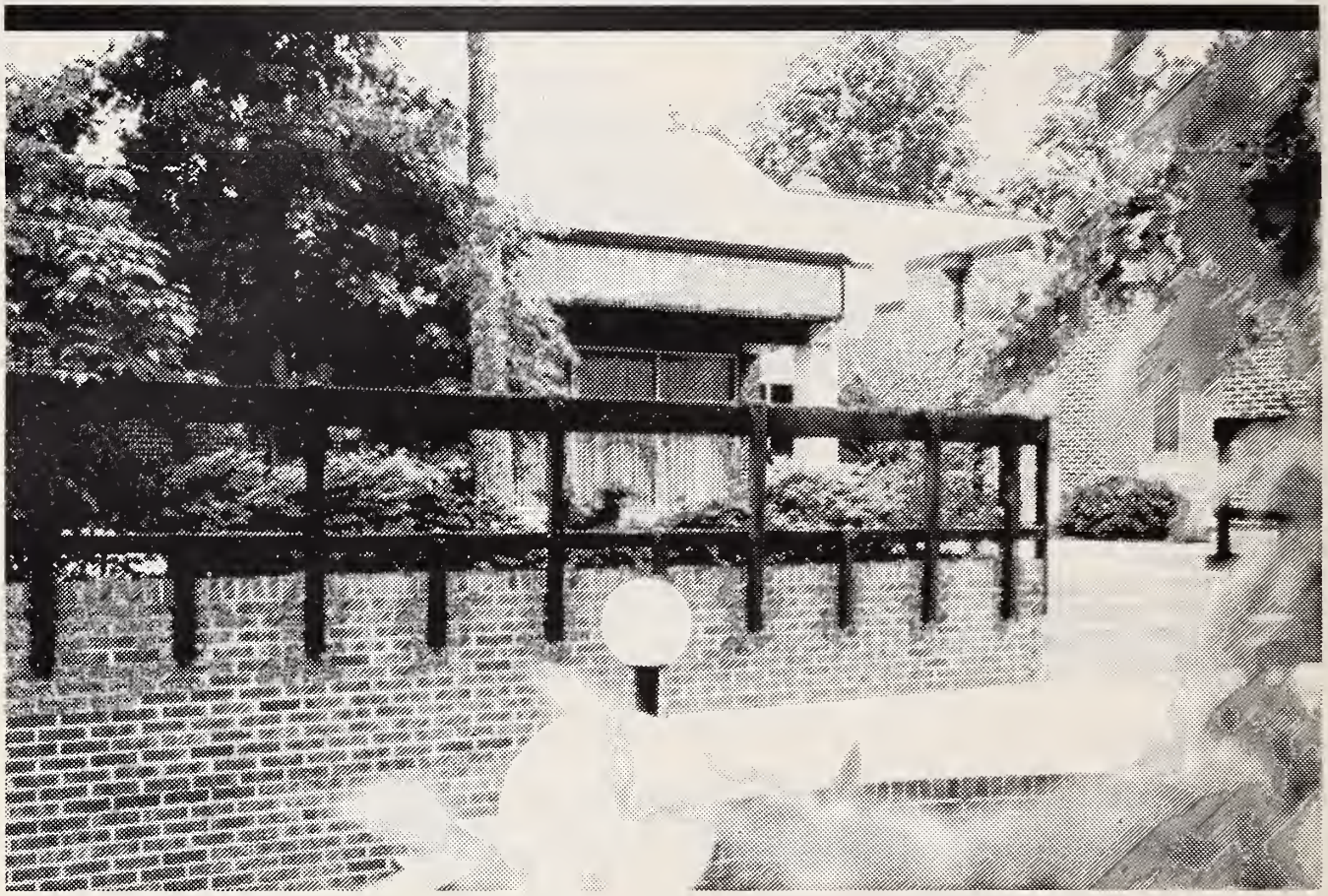
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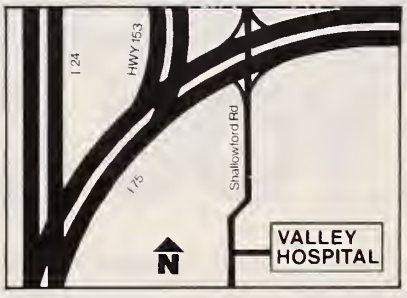


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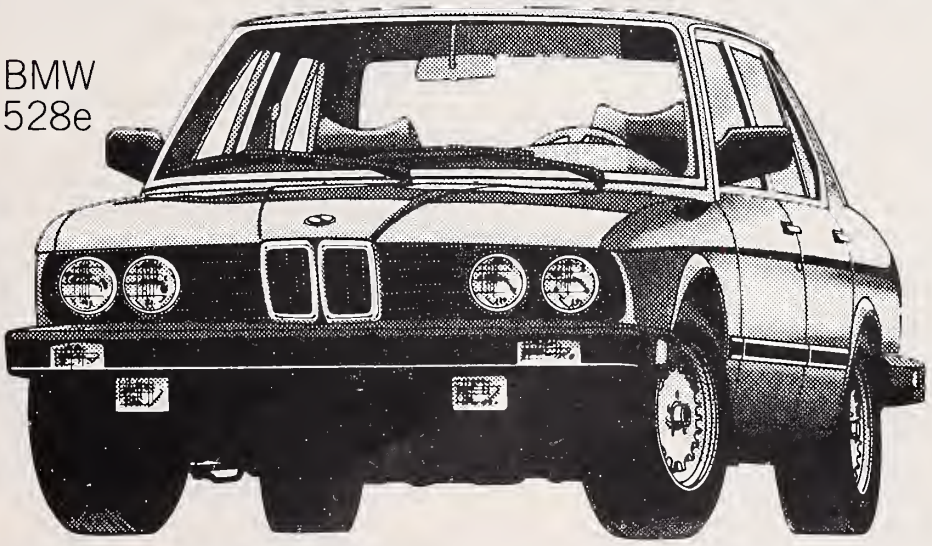
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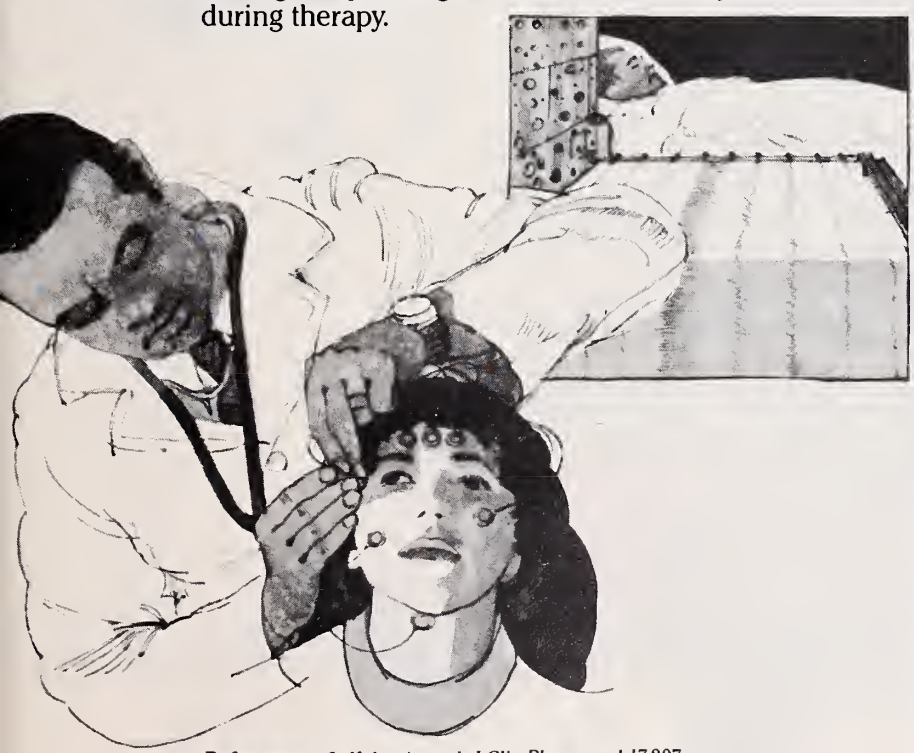
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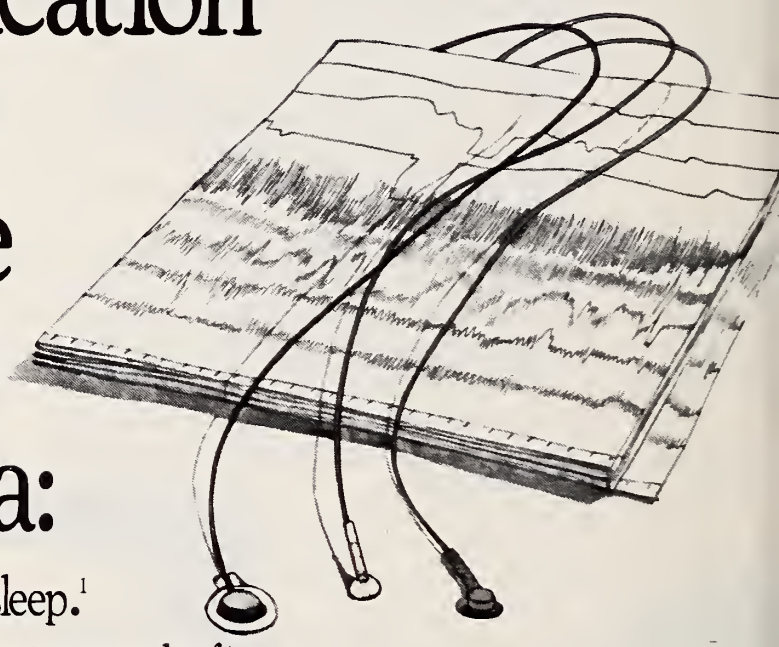
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The subscription price per year for members of the Medical Association of Georgia is $7.50, included in the annual membership dues. The subscription price for nonmembers is $15.00 in the United States, Canada and Mexico, and $17.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, GA 30309-3990. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, GA 30309-3990.

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THE COVER

This month's cover artwork is by Richard C. Hagerty, M.D., a 7th-year resident in plastic surgery at Grady Memorial Hospital in Atlanta. (We erroneously identified him last month as a 4th-year resident.) Dr. Hagerty's art is available at Fay Gold Gallery in Atlanta.

Incidental Intelligence . . .

Alcohol and Fatal Injuries in Fulton County, 1982

Recognizing that homicides, suicides, and motor vehicle collisions (MVCs) are among the leading causes of premature loss of life in the United States, the Office of Epidemiology of Georgia's DHR has initiated a surveillance system in several counties within the state to identify the extent to which factors such as alcohol and drug abuse are associated with fatal injuries. As an initial effort, a retrospective survey was conducted to ascertain the blood alcohol content (BAC) of all victims of fatal injury events which occurred in Fulton County in 1982. The study was conducted with the collaboration of the Fulton County Medical Examiner's Office, the Georgia Crime Laboratory, the Georgia Department of Public Safety, Alcoholism and Drug Services, Georgia Department of Human Resources, and the Centers for Disease Control.

The Fulton County medical examiner records were reviewed for all persons classified as homicide, suicide, or MVC victims. However, only persons who died within 6 hours of the injury event and who had a BAC obtained were included in data analysis. The Department of Public Safety's collision report forms were also reviewed to obtain information on the BAC of drivers involved in MVCs which resulted in a fatal injury to a passenger or a pedestrian.

Of 129 homicide victims, half (51%) were legally intoxicated (i.e., BAC $\geq$ 0.1gm% at the time of death; 77% of black males and 71% of white males had been drinking alcohol before the injury event (BAC $>$ 0).

Of 90 suicide victims, the frequency of alcohol use was relatively low. Only 20% of the victims were legally intoxicated at the time of death.

Seventy-eight victims of MVCs in Fulton County in 1982 died within 6 hours of the event. At least 1 driver was legally intoxicated in 39 (85%) of 46 MVCs in which BACs of drivers were collected, and 42 MVCs (91%) involved at least 1 driver who had been drinking alcohol. Eighty-two percent of the legally intoxicated drivers were at least 25 years old, and 77% were male.

These data convincingly demonstrate the magnitude of alcohol use among victims of fatal injuries, particularly among homicide and MVC victims. They also highlight the need to obtain the BAC on all persons potentially responsible for a fatal injury, including all drivers involved in motor vehicle collisions and perpetrators of violent crime.

Currently, 6 Georgia counties (Clarke, Dekalb, Fulton, Murray, Walker, and Whitfield) are participating in a surveillance system to monitor alcohol and drug use among victims of fatal injuries. A questionnaire is completed by the medical examiner's or coroner's office on each victim of a fatal injury at the time the death is reported. A blood specimen is sent to the Georgia Crime Laboratory for determination of BAC and a toxic screen. A MVC report form providing information on alcohol use of all drivers involved in fatal-injury events is completed by the Department of Public Safety in conjunction with the investigating agency. The Office of Epidemiology, Georgia Department of Human Resources, is collecting this information monthly and is analyzing the data by county annually. The data can then be used at the local and state level for planning and allocation of resources and to increase public awareness of the extent of the problem.

In the past, many programs or measures taken to deter alcohol misuse have suffered from the absence of any method to monitor success or failure. Ongoing surveillance will provide mental and physical health programs, law enforcement agencies, and policymakers with an increased ability to plan intervention strategies and to monitor the effects of their efforts to curb fatal injuries associated with alcohol misuse.

(Contributed by Ruth Berkelman, M.D., Medical Epidemiologist, Centers for Disease Control; reprinted in part from Georgia Epidemiology Report.)

Editorial Note: Injuries are the leading cause of premature mortality in Georgia. The cost to Georgians for these injuries is high. More information is needed about injury causation to direct our efforts toward injury prevention. Often, cause is characterized by the term "accident," which connotes chance or fate, while actually many injuries, like diseases can be prevented. In the above survey, the term "motor vehicle collision" has been used, rather than the commonly used term "motor vehicle accident." The use of the term "accident" should be avoided when describing the cause of an injury event.

Role For Physicians in Hospice Urged

A new hospice benefit Medicare to be initiated on November 1 will be "beneficial" to many patients but regulations to implement it should be modified "to give greater recognition to the role of the patient's attending physician," the American Medical Association has told Medicare officials.

In commenting on the regulations, the AMA suggested several specific areas where the role of the attending physician should be strengthened. The comments note that hospices will be paid a flat per diem rate and call for the continued involvement of the attending physician as a "safeguard because the hospice has a significant incentive not to provide care that would result in incurring expenses in excess of the reimbursement amount."

Scholarship Fund to Honor Slain Physician

A Scholarship Fund has been instituted on behalf of John Rice Hudson, M.D., a 1981 graduate of the Medical College of Georgia who was killed Oct. 23, 1983, in Beirut, Lebanon. Navy Lieutenant Hudson, aged 28, was the only physician assigned for shore duty with the U.S. Marines, whose Headquarters building was instantly destroyed by terrorist explosives. John and several other hospital corpsmen who were quartered in the ill-fated building died in the atrocity along with 239 other American servicemen.

Dr. Hudson received most of his medical education through the Navy scholarship program. After 1 year of residency in Family Practice in the MCG program, he reported to Camp LeJeune, North Carolina, in July, 1982. He received field training with the Marine unit to which he was assigned. This battalion was sent to Lebanon for 6 months of "peace keeping" duty. In late summer of 1983, the hostilities constantly threatened the safety of the Marines and fatalities began to mount, one or two at a time. Dr. Hudson's letters home made clear the vulnerability of their position. He foretold that he might not make it home alive in November when replacements were due.

Dr. Hudson's wife, the former Lisa Helton of Milledgeville, has requested that anyone wanting to honor him do so through the Scholarship Fund. This can be done by contributing to: MCG Foundation, Inc., John Rice Hudson Scholarship Fund, c/o Medical College of Georgia, Augusta, Georgia 30912.

Medicare Deductibles To Rise January 1

The nation's 30 million Medicare beneficiaries will have to pay about 17% more out of pocket for hospital stays in 1984 as the Medicare hospital deductible increases from $304 this year to $356 on January 1, the Department of Health and Human Services has announced. The premiums beneficiaries pay for their supplementary medical insurance (Part B) will rise from $12.20 to $14.60 a month on January 1.

FDA's OTC Drug Review Winds Down

After 11 years of effort, the Food and Drug Administration has compiled a new list of the nation's safe and effective nonprescription drugs.

Only one-third of the 700 key ingredients reviewed were found to be safe and effective. However, many popular products contain both effective ingredients and ineffective ingredients which are still being tested.

As a result of the study's recommendations, consumers can now buy many former prescription drug products over-the-counter, such as: hydrocortisone; two antifungals; seven antihistamine or nasal decongestant ingredients; diphenhydramine hydrochloride and diphenhydramine monocitrate as nighttime sleep-aid ingredients; and dyclonine hydrochloride as a pain reliever and anesthetic in mouthwashes, gargles, and lozenges.

But the review also pulled many over-the-counter products from the market, such as: sweet spirits of nitre; camphorated oil; hexachlorophene, and all daytime sedative products promoted to relieve "simple nervous tension."

Many manufacturers have reformulated products to take advantage of the study's recommendations. Additionally, some manufacturers improved directions, warnings, or consumer information on product labels. Much work still remains, however, to convert the study's recommendations into regulatory action, the FDA says.

Congressional Attempt to Reschedule Quaaludes

Two new bills — HR 1055, introduced by Rep. Larry Smith (D-FL), and HR 1097, sponsored by Rep. J. Roy Rowland, M.D. (D-GA) — would change the status of methaqualone (Quaalude) from Schedule II to Schedule I, taking it out of the hands of physicians and putting it in the same category as other drugs with no accepted medical usage, such as heroin, LSD and marijuana.

The dangers and advantages of the drug were recently debated at hearings before a subcommittee of the House Energy and Commerce Committee. Supporters of the proposed legislation say that methaqualone has limited therapeutic advantages and can be easily substituted. Opponents of the legislation contend that the drug offers distinct advantages: for instance, it may be used in conjunction with anticoagulant therapy and can be used safely for longer periods of time than barbiturates.

Because virtually all sedative and hypnotic drugs have the potential to cause psychic and physical dependence, methaqualone should stay on the market, says Mark Novitch, M.D., Acting Commissioner of the Food and Drug Administration. Besides, the drug is no longer frequently prescribed by physicians, causing a decline in street abuse also, he says.

The change in scheduling is also opposed by the American Medical Association, which argues that the best approach to stop drug abuse is to eliminate the source of illicit drug diversion rather than banning the product. Moreover, Quaalude has an accepted use as a hypnotic agent, and does not satisfy the criteria for rescheduling. The AMA adds that the appropriate route for rescheduling is through the administrative process, not through legislation.

On Keeping One's Spirit Up

I had already come to understand that Melvin Foster had a unique way of putting things. He seemed, almost unconsciously at times, to come out with clarifying remarks characterized mostly by Churchillian simplicity. Melvin was from the north Georgia hills, 65 years of age, his hair crewcut as befitted the 1930s. He was hard of hearing to the point of requiring a battery-assisted device attached to his horn-rimmed glasses before even minimal comprehension was obtained. One shouted at him or talked in a less-than-muted voice to gain some degree of understanding. It seemed to help that he always laughed a lot as he talked, for it filled the gaps between the clarifying statements and the time it took one to put it all together. Conversations with him had become a challenge in comprehension. I had grown to like him.

The abdominoperineal resection done for a low-lying rectal carcinoma only 3 weeks earlier had gone well initially, but now he had been brought back to drain the perineal abscess. I walked in one Friday morning to find him somewhat less than his usual ebullient self. Worry was evident in his face, the glasses with the device attached were already in place.

I thought I knew about the effect of the emotions and the "will to live" and all the other nebulous contributors to the healing process. We have talked about them endlessly through the years, and I knew they were important. I was beyond the point of thinking that stitches and blood transfusions and even protein synthesis accounted for all of the healing process. I knew that something else was there that was often hard to put one's finger on, and surely difficult to manufacture, that played its part in determining whether one lived or died, and if one lived, how quickly he or she recovered from a surgical operation or any other illness. I thought I knew all these things, but Melvin had his own lesson to teach.

And so, as I walked into the room that morning and looked at the slightly furrowed brow, I missed the ever-present chuckle and laugh. "How are things going, Melvin?" I asked.

He had the answer ready, as he usually did. "Just trying to keep my spirits up, Doc — you know, if you don't keep your spirits up, you might be doing pretty good but you wouldn't know it." There went Melvin again, I thought, taking all the complex psychologic contributors to the healing process and arranging them neatly in front of me so that I might understand more easily just what was happening.

I felt better right away. I left the room quickly to think about it — but primarily to "keep my spirit up." When I got it up, I was amazed to find that I was doing pretty well. I just had to get my spirit up to realize it. *(Charles R. Underwood, M.D., general surgeon, Marietta.)*

Beyond DRGs?

Just as hospitals across the country were gearing up for the advent of Medicare's new diagnosis related groups (DRGs) payment scheme on October 1, organized labor and some of its congressional supporters staged a hearing to promote a labor-backed bill that goes far beyond the new Medicare plan.

Called the "Health Care Cost Control Act of 1983," the bill would establish federal caps on payments to both physicians and hospitals, require physicians to take all Medicare claims on assignment, and increase federal Medicaid payments to states that set up their own systems to control hospital and physician fees. Both the federal and state controls would apply to all patients — not just Medicare and Medicaid beneficiaries.

Introduced earlier this year by Sen. Edward Kennedy (D-MA) and Reps. James Shannon (D-MA) and Barbara Mikulski (D-MD), the bill was the subject of a hearing by the House Ways and Means Health Subcommittee. It was endorsed by labor groups and supported in part by the Health Insurance Association of America.

It was opposed by the American Hospital Association, the Blue Cross and Blue Shield Association and the American Medical Association, whose representatives called it an extension of the hospital cost caps proposed by the Carter Administration and rejected by Congress.

The cost cap plan is not likely to be seriously considered this year in a Congress waiting to see how effective hospital DRGs will prove. But since DRGs are expected to delay Medicare bankruptcy only to 1990 at best, Congress soon will have to seriously address Medicare's financial problems and Kennedy appears to be positioning for that debate.

Kennedy reportedly will offer another alternative which he considers a "refinement" of that plan. He and Rep. Richard Gephardt (D-MO) plan to introduce a proposal to extend DRGs to all payers and apply it to physician fees as well as to hospitals.

AMA Board member Alan R. Nelson, M.D., testifying in October, said the Kennedy-Shannon approach is based on "strict regulatory controls, arbitrary and rigid caps, massive bureaucratic administration, and harsh penalties. Administration of the program would be highly complex and intrusive into the management of hospitals and the delivery of Medicare in this country," and "would provide no safeguards to assure quality care," Dr. Nelson said.

Dr. Nelson, a Salt Lake City physician specializing in internal medicine, called the proposal to limit physician fees "counter-productive" and "unfair" since it would restrain physician charges while placing "no such restraints on the rest of the economy." He also warned that mandated assignment of Medicare claims, in conjunction with proposals to hold down Medicare reimbursement to physicians, could adversely "affect access of Medicare patients to the physician of their choice."

MEDICAL MEETING CALENDAR

JANUARY

13-14 — *Atlanta:* **MAG Leadership Conference.** Contact James M. Moffett, Exec. Dir., 938 Peachtree St., NE, Atlanta 30309. PH:404/876-7535 or 1-800-282-0224 (toll free in Ga.).

FEBRUARY

1-4 — *Montego Bay, Jamaica:* **The Sixth Annual Pediatric Postgraduate Course.** Sponsored by the Scottish Rite Children's Hospital. Category 1 and AAFP prescribed credits. Contact Judson L. Hawk, Jr., M.D., Dir. of Ped. Ed., Scottish Rite Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH:404/256-5252.

9-14 — *Atlanta:* **American Academy of Orthopaedic Surgeons 51st Annual Meeting.** Contact AAOS, 444 N. Michigan Ave., 15th Floor, Chicago, IL 60611. PH:312/822-0970.

18-25 — *Park City, Utah:* **2nd Annual Winter Urology Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

20-25 — *Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Educ., MCG, Augusta 30912. PH:404/828-3967.

24 — *Atlanta:* **Clinical Problems in Neurology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

27-Mar 2 — *Paradise Island, Nassau, Bahamas:* **Problems of Chronic Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

MARCH

4-10 — *Keystone, CO:* **Snow Job in OB/GYN.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-9 — *Durango, CO:* **Seventh Annual Symposium on Emergency Medicine.** Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

APRIL

4-6 — *Atlanta:* **Techniques in Orthopaedic Surgery.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

5-7 — *Atlanta:* **Introduction Into Percutaneous Transluminal Angioplasty III.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

6-7 — *Callaway Gardens:* **4th Annual Geriatric Conference For Primary Physicians.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

9-12 — *Atlanta:* **Demonstrations In Percutaneous Transluminal Angioplasty XI.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-14 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

14-15 — *Atlanta:* **The Cardiac Patient: Management for Cardiopulmonary Bypass.** Category 1 credit. Contact Dir., Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5696.

16-18 — *Atlanta:* **Pediatric Infectious Diseases and Immunology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

27-28 — *Augusta:* **Ocular Toxicology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

27-29 — *Atlanta:* **Advanced Cardiovascular Diagnostic, Therapeutic, Rehabilitation, and Patient Follow-Up Methods.** AMA Category 1 and AAFP prescribed credits. Contact International Med. Educ. Corp., 64 Inverness Dr. E., Englewood, CO 80112. PH:800-525-8651.

30-May 5 — *Augusta:* **19th Annual Family Practice Symposium.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Educ., MCG, Augusta 30912. PH:404/828-3967.

MAY

11-12 — *Atlanta:* **3rd Annual Update of the Diagnosis and Treatment of Lupus Erythematosus.** Category 1 credit. Contact Stephen T. Balch, M.D., Dir., Jacquelyn McClure Lupus Treatment Ctr., 3200 Howell Mill Rd., NW, Atlanta 30324. PH:404/351-0351.

JUNE

7-9 — *Atlanta:* **Clinical Topics in GYN-OB.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

11-14 — *Kiawah Island, SC:* **Internal Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

21-23 — *Hilton Head, SC:* **Neurology.** AMA Category 1 and AAFP prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

JULY

12-14 — *Kiawah Island, SC:* **Obstetrics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

23-25 — *Kiawah Island, SC:* **Pediatric Update — 1984.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

26-28 — *Kiawah Island, SC:* **Clinical Genetics.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

AUGUST

2-5 — *Kiawah Island, SC:* **Critical Care Medicine.** AMA Category 1 and AAFP prescribed credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

6-10 — *Hilton Head, SC:* **Your Practice, Your Money, Your Family.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH:404/828-3967.

11 — *Atlanta:* **Experimental Hematology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

12-16 — *Amelia Island, FL:* **Abdominal and Neuroimaging — Interventional Techniques.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695.

13 — *Atlanta:* **Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., NE, Atlanta 30322. PH:404/329-5695



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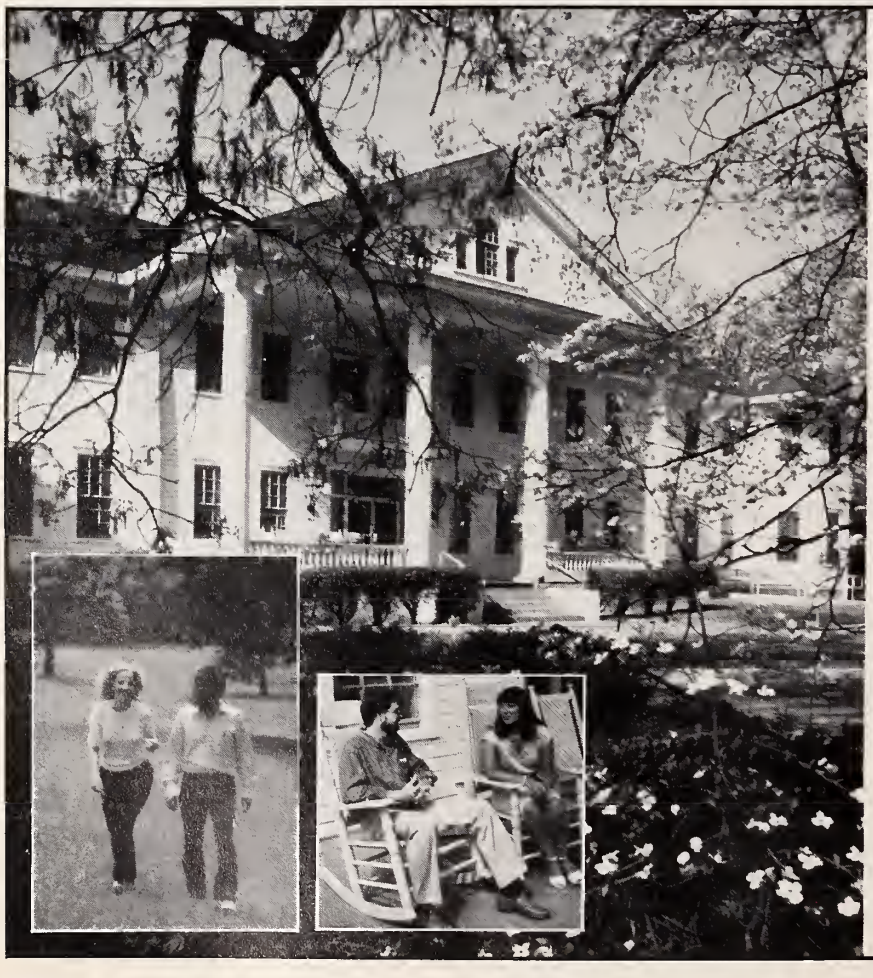
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Medicine in Early Georgia (Savannah)

JULIAN K. QUATTLEBAUM, SR., M.D., *Savannah**

Training Early Physicians

THE FIRST practicing physician in the colony of Georgia was Dr. Samuel Roberio Nunez, a wealthy, well educated, and highly intellectual Jew, who with his family came over with the second expedition to the new colony. He had been forced to leave Spain to escape the inquisition in Lisbon. The Nunez family could trace its ancestry back over 400 years, and it included many highly educated doctors and many graduates of the University of Madrid.

The Nunez family arrived July 10, 1733, at a time when a very severe epidemic of "Bloody Flux" or dysentery with a severe gastroenteritis was raging in the colony. Dr. Nunez volunteered to help control the epidemic and immediately instituted improved sanitary measures, insisting on the colonists obtaining a fresh water supply, cooking their food properly, controlling insects, and constructing latrines. This soon brought the epidemic under control. Dr. Nunez continued serving the new colony in many ways and was tireless in his efforts to improve the health of the settlement. His abilities were of the highest caliber and his knowledge of drugs exceptional.

Dr. Nunez founded the first apothecary shop in Savannah, the site being where the old Manger Hotel now stands. He delivered the first two white babies born in the colony in 1734. He later moved to Charleston, South Carolina.

Fernan Marcos Nunez, a direct descendent of Roberio and probably his last male descendant and a native of Savannah, died in that city in 1967. He was a highly trained pathologist, having taught at several medical colleges, and spent the last years of his life practicing his specialty in Savannah.

Among other colonial physicians was Dr. Noble Jones, who landed with General Oglethorpe and helped choose a site for Savannah. A year later the Salzburgers brought their physician with them, a Dr. Twiffler, who with Oglethorpe and some Indian guides searched for a site and chose Ebenezer because of its good water supply and drainage.

For the next 70 years, medicine was practiced in the colony by doctors already educated in Europe, by American-born apprentices trained by those doctors, by midwives, planters' wives, and ministers. Many of the early physicians were also active in politics and government, serving as mayors, aldermen, and also as members of the legislature. Some served in military and judicial positions. Many were botanists, interested in growing herbs and drugs in the colony, which could be produced cheaper than the Spanish drugs which came in by boat.

Formation of the Georgia Medical Society

The character of Georgia's medicine made a significant departure from the past during the first decades of the 19th century. The day of the apprentice-trained and the self-trained practitioners was rapidly ending, and a new type of physician was beginning to appear. A growing number had spent at least 1 year at a formal school, and increasing numbers completed the 2-year course required for a medical degree. By the early 1830s, at least thirty degreed physicians were practicing in Georgia. After the opening of a degree program in early 1830 at the Medical College of Georgia in Augusta, the number

* Dr. Quattlebaum recently retired from nearly 60 years of practicing general surgery. Send reprint requests to him at 3710 Waters Ave., Savannah, GA 31404.
This paper was read before the First District Medical Society of Georgia, April 20, 1983.

would be greatly increased before the Civil War. As the number of degreed physicians grew, so did the need for formal medical organizations. One of the needs for such societies was to lobby for much needed health regulations and also to regulate the practice of medicine in the community and to combat the so-called irregular practitioners, who in the minds of many were incompetent or simply "quacks." Most formally trained physicians saw a medical society as an indispensable tool to the exclusion of these outlaw practitioners. This gave birth to the first of these societies, The Georgia Medical Society on June 28, 1804. Dr. Wimberly Jones was elected first president; Dr. John Irvin, vice-president; Dr. Lemuel Kolloch, treasurer; and Dr. John Grimes, secretary. *The importance of the Georgia Medical Society in Georgia's history cannot be overemphasized.* This group encompassed literally all of the city's formally trained physicians. Not only did the Georgia Medical Society organize local physicians and attempt to exclude poorly trained, irregular physicians from practicing in Savannah, but it adopted the State's first code of medical ethics and drew up a local fee bill in an effort to regulate policies. It campaigned for and finally achieved a program of systematic vaccination against smallpox, carried out health surveys of Savannah and surrounding counties, founded a medical library, and conducted extensive studies of Savannah's major epidemic diseases: malaria, yellow fever, and smallpox. One of its most important contributions was the formation of the first systematic anti-malarial program begun in the United States. This program eventually drained most of the swamps and rice paddies surrounding Savannah, with a marked decline in the mortality rate.

The importance of the Georgia Medical Society in Georgia's history as well as the history of medicine in Georgia cannot be overemphasized.

Dr. John Grimes, the secretary of the Georgia Medical Society, was a descendant of a Virginia family and a resident of Wilkes County, Georgia, before coming to Savannah in 1804, after a period of study at the University of Pennsylvania Medical School. Dr. Grimes died of yellow fever in 1816 at the age of 35, but he lived a life of great service to the Georgia Medical Society and to the community, being for a number of years a member of the State Legislature where he endeavored against much ignorant opposition to advance the health interests of Georgia.

One of the first objectives of the new medical society was to secure a medical license law. The first effort made in 1805 did not succeed. In fact, a medical law was not secured until 1821, after the death of Dr. Grimes.

The numerous crises confronting the Georgia Medical Society during the early 19th century forced the society's interest and attention inwardly. This created a feeling among some of the early societies in other areas of Georgia that the Georgia Medical Society had assumed an attitude of aloofness and arrogance toward them. This was certainly not the case; however, the ever increasing epidemics and the continuous battles with the irregular or self-educated practitioners, the distances between the societies, and the difficulties of transportation made closer affiliation with them arduous indeed. The Savannah physicians had their hands full at all times.

The Blight of Fevers

The most important crisis was the mounting mortality caused by the increasingly serious epidemics of malaria and yellow fever. In 1817 and 1818, the Society began to issue periodic reports during the fever months (June-September), cataloging the number and types of fevers within the city and how best to deal with them. It was from this informal reporting that the Board of Health arose during Savannah's first major yellow fever epidemic in 1820.

The members of the Georgia Medical Society were equally concerned with what they thought was a dangerous increase in the number of quacks and incompetents practicing within the city. The growing popularity of sectarian medical theories was, however, often a direct reaction against the abuse of traditional practitioners who used harsh bleeding, purging with chemicals, and blister methods. The popularity of many of the so-called "quacks" came less from their success in curing patients' ills than from the fact that they seemed to kill fewer patients than their formally trained competitors. Although the irregulars frequently opposed bleeding and the use of such mineral based drugs as calomel, their treatment was not always for the faint-hearted. The irregulars also fought hard to repeal the State Licensing Act, and they were successful in doing so in 1836 when the legislature repealed the 1825 act and again left each individual free to decide who was and who was not qualified to practice.

With the formation of the Medical Association of Georgia the fight for control of practice was continued and the licensing act was repassed in 1839 and remained in effect until 1881.

The 19th century was the golden age for the irregular practitioners in Georgia, and many similar philosophies, such as homeopathy, hydropathy, chemothermoism, and others flourished. In Georgia, the fight for control of practice between the

sectarians and traditional medicine continued for most of the century. In 1881, a third licensing act was passed which created three Boards of Medical Examiners; one for the traditional practitioners, one for the homeopaths, and one for the so-called eclectic school, which brought about peace after a fashion among all concerned.

Although nothing was more numerous and common in Savannah than mosquitoes, they were not even thought of as a possible cause of yellow fever.

Before the advent of scientific medicine, Savannah suffered through various epidemics from time to time. Such diseases as malaria, yellow fever, "pestentular fever," and other fevers and dysentery were common and usually caused great loss of life. The cause of these epidemics was usually unknown, treatment was often worse than the disease and the medical care was ineffective, at times approaching folklore in variety. "Strangers Fever," later known as yellow fever and first called "Siam" fever, was most deadly. The city was still surrounded with lowlands, swamps, marshes, and rice paddies which were breeding grounds for mosquitoes and other insects. Yellow fever usually struck in the summer months from June to October and ended with the coming of cold weather, for what are now obvious reasons, but at that time and until 1900 was a complete mystery. For over 400 years, the cause of yellow fever and most of the other fevers was unknown. All kinds of theories as to the cause existed. It was thought by some to be from filth and garbage that accumulated and with its decomposition released poisonous vapors; the miasmas of the swamps was a popular thought and in some areas cannon were fired at sundown over the swamps to "dissipate" the miasmas, a rather hard way to kill mosquitoes. Some thought it was helpful, and perhaps it was. It was also considered by some that the cause was imported by the ships that called on the city. Although nothing was more numerous and common in Savannah than mosquitoes, they were not even thought of as a possible cause, and the swarms of them were considered as nothing but a nuisance. Unbelievably, Dr. Joseph Nutt of Mobile and before that a native of South Carolina, wrote in 1847 "that insects could transmit 'strangers fever' and probably so could the mosquito." This thought was again expressed some years later but this idea went unnoticed until the work of Walter Reed and his associates, which incriminated the mosquito in 1900-1901.

These epidemics were indeed terrible. Life expectancy for those affected was usually short and often entire families succumbed to the disease in just a few days. In Charleston, which almost always had epidemics concomitantly with Savannah, and in Savannah there were twenty-seven (27) epidemics from 1800 through 1876, and in the terrible epidemic of 1820 over 4,000 died. The disease was rare in other parts of Georgia away from the coast. The importance of this should also have been more carefully studied. In 1854, the city was struck by a very severe yellow fever epidemic. This caused a wild panic among the population, and two-thirds of those able to do so left the city at the height of the plague, going to Macon, Augusta, and 700 to Philadelphia by boat, 40 of whom died in the Philadelphia quarantine station. No one in that city contracted the disease, however — another significant fact. About 6,000 remained in the city and in 12 weeks, the mortality had reached nearly 1,000 and included 10 physicians, 10 medical students, and many very prominent people. The sick and dead together were numbered at about 5,000.

Severe epidemics occurred in Charleston and less severe epidemics in Savannah in 1836. Cases and epidemics continued to occur until the Walter Reed Commission found the mosquito to be the cause. This discovery was too late to prevent the worst epidemic in the city's history in 1876, when over 2,066 people died, 33 in one day — September 20.

Treatment took various forms from doing nothing but nursing care and cold water sponges and packs for the fever, which was certainly more effective than the treatment with a variety of medicines, purges, bleeding, enemas, and blisters as prescribed by the formally trained doctors, which were undoubtedly responsible for many of the deaths. Quackery was widespread, with many proposals of all kinds of remedies. There were many who preferred the care of the irregular sectarians to that of the recognized physician. This, however, was only a case of small choice of rotten apples.

Samuel Thomson and The Thomsonians

The empiric therapeutic system of Samuel Thomson, a bitter adversary of the traditional medical group, was based largely on the use of steam, botanies, and strict avoidance of bleeding. Thomson was convinced that all diseases arose from one general cause and that one remedy could effect a cure. The cause was *cold,* and the cure was *heat.* He believed that all animal bodies are formed of four elements — earth, air, fire, and water. Any imbalance among these four elements which reduced the power of heat resulted in illness. To effect a cure, one had to restore the balance. Although Thomson fervently opposed bleeding and the use of drugs such as calomel, the treatment he used was worse. A sample prescription was as follows: A steam bath 30 min-

utes in duration; when sweat thick as your finger rolled off, the body was washed with *cold* water and the patient was put in bed with hot bricks to bring back the heat. Then a powerful vomative, composed of "bayberry, cayenne pepper, and lobelia," was mixed in 40 proof brandy and administered to the patient, after which hot water was consumed until these "ensured the most extraordinary vomiting." The patient was then given a second steam bath followed by a second cold bath, a second session with the hot bricks, followed by two enemas of "penny royal, cayenne pepper, and lobelia." Nothing is said about the treatment for the next day. It is not unlikely that a patient dying of yellow fever, or that anyone sick or well, could have survived such an ordeal. The traditional physicians almost matched this with some of their own concoctions "aided" by excessive bleeding.

The growing popularity of sectarian medical theories was often a direct reaction against the abuse of traditional practitioners.

Samuel Thomson was born on a New Hampshire farm in 1769 and his father, who was as harsh and unyielding as the farm itself, put him to work at the age of five. His life was hard, bleak, and generally unhappy. Personal experiences turned Thomson completely against traditional medicine. He saw his mother die of measles while she was under the care of several local physicians. Earlier he felt he had cured himself of the same disease through the use of "botanies." A year after his mother's death, his wife became seriously ill following childbirth. Several local traditional physicians treated her but she grew steadily worse and was near death. Thomson fired the traditional physicians from the case and called in two root doctors. One day later his wife appeared completely cured. It is uncertain whether this miraculous result occurred from what the root doctors did or from discontinuing what the regular physicians had been doing.

Thomson became greatly interested in herbal medicine and gained quite a local reputation as a folk healer. He patented his therapeutic systems and marketed it through his son and other representatives and agents, who travelled about the country selling copies of his two volume work: "A New Guide to Health" and "A Botanic Family Physician." He then began a large scale effort to popularize his "system." His representatives spread the gospel throughout New York, Ohio, and the West. They first came to Georgia in 1818 with a special personal agent. Savannah physicians had had many bouts with irregulars but they had never encountered anything like the "Thomsonians." They travelled extensively through the state and promptly gained popularity and acceptance. They gave the traditional practitioners in Georgia "fits." Thomson's widespread activities throughout the United States indirectly led to the formation of the American Medical Association.

Savannah's Two Medical Schools

Many doctors and other sensible people realized the folly and danger of such treatment for yellow fever patients, and some of the more intelligent physicians prescribed nothing but cold water baths and sponging and such stimulation as could be given. The need for better educated doctors and more study of the cause of diseases was obvious and two medical schools were established in Savannah: the Medical College of Savannah in 1852 and the Oglethorpe Medical College in 1854. Much rivalry existed between the two schools but a number of doctors served on each faculty.

From the scant information available about these two schools, one is impressed by the excellency of their instruction. In addition to courses of didactic lectures, the students were given bedside instruction in diseases. The wards of the Savannah Hospital and the St. Joseph Infirmary and the Georgia Infirmary were freely used, in an effort to combine clinical teaching with lectures. Students were permitted to attend surgical procedures and unusual cases were presented to them.

The faculty of the Savannah Medical College purchased a complete life-sized anatomical model "which greatly facilitated the study of the mechanisms of the whole body." Ample dissecting material was furnished to the students without charge. The office of "House Pupil" or intern was available to the most deserving student. The St. Joseph Infirmary and the Georgia Infirmary also appointed interns from the best students. In 1856, the Oglethorpe College gave a microscope to the student who furnished the best collection of specimens for the museum. The dissecting room was open throughout the course and as many subjects were furnished as could be dissected by the entire class.

Both schools were closed during the Civil War, the Oglethorpe College permanently. However, the Savannah Medical College reopened after the war and continued in operation until it was closed in 1881 because of lack of funds, which reflected the terrible state of the economy in Georgia and throughout the South after the war.

I think we of the Georgia Medical Society and Savannah in general should be proud of these two schools. They furnished excellent training for the times. They gave bedside teaching before such instruction was made so important and universally instituted by the great Dr. William Osler years later.

Data indicate characteristics of alcoholic and drug addicted patients, evidence of the severity of their disease and of the psycho-social factors present, and evidence of the progressive nature of chemical dependence.

An Analysis of 100 Consecutively Admitted Alcohol and Drug Patients

W. FRANK McKEMIE, SR., M.D., and RALPH A. HUIE, JR., *Atlanta**

INPATIENT ALCOHOL AND DRUG services are available to patients in the Northeast Georgia Mental Health/Mental Retardation Consortium at the Georgia Mental Health Institute in Atlanta. The Consortium consists of 17 northeast Georgia counties of which two are urban, three suburban, and 12 rural. Patients are referred to the Alcohol and Drug Service largely through mental health centers in these counties. As often as possible, they are returned to these centers for the after-care vital in their recovery.

Mental Health Centers refer only those patients whose physiologic dependence is manifested by a withdrawal syndrome requiring inpatient detoxification or those whose diagnosis and management cannot be reasonably carried out in an outpatient program.

The Alcohol and Drug Service uses a multidisciplinary approach to the care and treatment of its patients. It utilizes the individual and integrated skills of physicians, nurses, social workers, chaplains, alcohol and drug counselors, pharmacists, and technicians. The physician accomplishes detoxification and medical care of the patients as a member of the team.

The objectives of the service are: 1. Detoxification of patients who are in a withdrawal syndrome. 2. Evaluation of the physical and biochemical manifestations of chemical dependence. 3. Diagnosis and management of other concurrent physical or psychiatric disease. 4. Education of patients about the disease of chemical dependence. 5. Orientation of patients to the use of group meetings in dealing with emotions and life problems. 6. Implementation of an after-care program whose main features are mental health center participation, Antabuse therapy, Alcoholics Anonymous involvement, and a relationship to spirituality in whatever sense they can experience it.

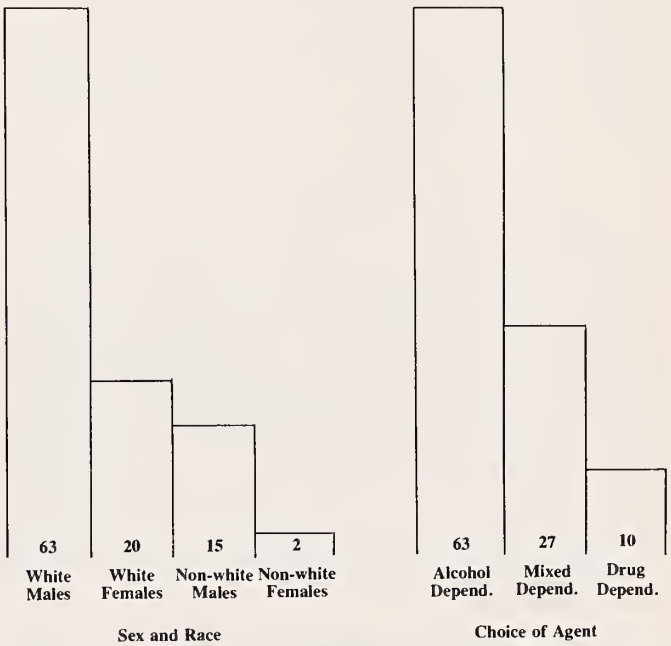


Figure 1 — 100 Patients, Georgia Mental Health Institute, by Sex and Race and by Choice of Agent, April, 1983

We felt it would be instructive to study some of the features of our service to detect patterns that might be in evidence. We have chosen to look at data collected on 100 patients consecutively admitted to the service over a period from April 1, 1983, to May 2, 1983. Data were collected in 18 categories which indicate characteristics of the patients we serve, evidence of the severity of their disease, evidence of the psycho-social factors present in addictive disease, of

* Drs. McKemie and Huie are with the Alcohol and Drug Service of the Georgia Mental Health Institute, 1256 Briarcliff Rd., NE, Atlanta, GA 30306.

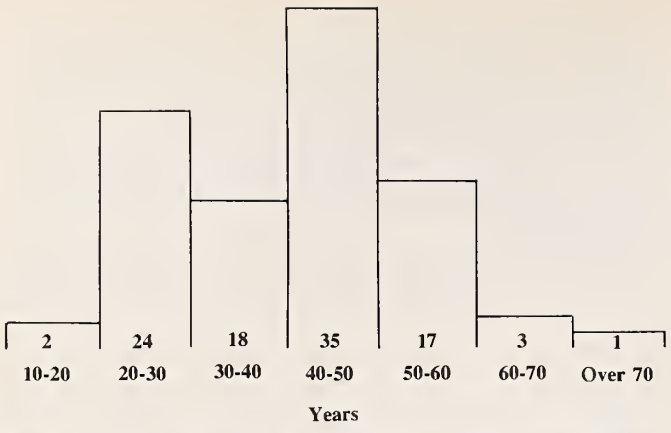


Figure 2 — 100 Patients, by Age Groups, Georgia Mental Health Institute, April, 1983

the progressive nature of chemical dependence, and of prognosis.

Data studied in each patient were: age, sex, race, first admission or re-admission, voluntary or involuntary status, marital status, principal diagnosis, legal involvement, state of employment, drug of choice, age at first drink or drug use, laboratory evidence of liver disease, macrocytic anemia, presence of other disease, detoxification used, referral source, religious activity or not, and follow-up at 30 days.

Method

All patients had an evaluation in the Admissions Section of the Georgia Mental Health Institute consisting of a history and physical examination. Those who were referred from a mental health center had also been evaluated there. On the Alcohol and Drug Unit, each patient had a complete blood count, urinalysis, serology, an SMA-22 (biochemical profile), skin test for tuberculosis, and/or chest x-ray. Data were obtained from these procedures and from the patient or family on an on-going basis as treatment and evaluation continued.

Results

Of the 100 patients, 63 were white males; 20 were white females; 15 were non-white males; and two were non-white females. Fifty-six were first admissions, not seen on this service before; 44 were re-admitted patients. Seventy-seven were voluntary and 23 were involuntary admissions. Many of the latter were brought on affidavits by the patient's family through the Probate Court. Twenty-two were married; 40 were divorced; 14 were separated; three were widowed; and 21 were single.

Alcohol dependence was the primary diagnosis in 63 patients; drug dependence with single or multiple agents was the primary diagnosis in 10 patients; mixed dependence, with the use of both alcohol and drugs, was the primary diagnosis in 27 patients.

Seventy-six patients stated that they were unemployed; 24 affirmed employment. Fifteen admitted legal charges or involvement. Only two affirmed religious belief to the extent of active involvement.

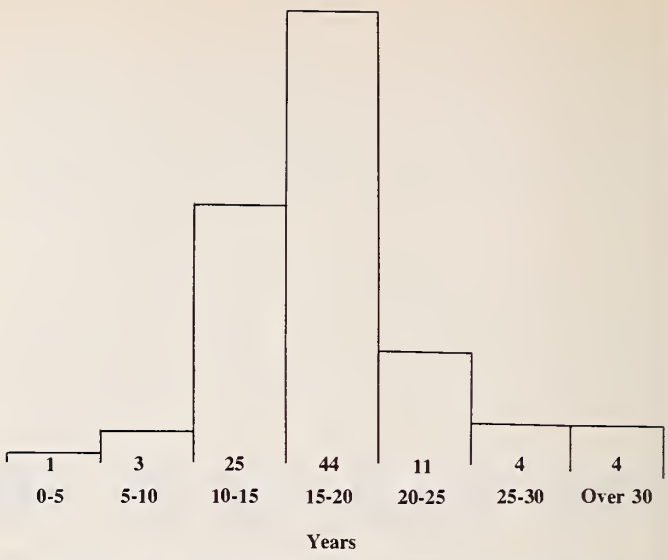


Figure 3 — Age of First Drink or Drug Abuse Episode in 100 Patients, Georgia Mental Health Institute, April, 1983

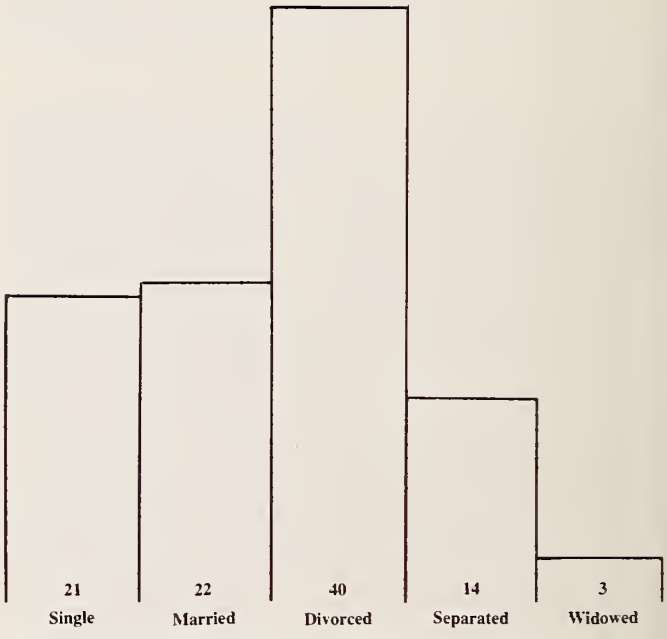


Figure 4 — 100 Patients, by Marital Status, Georgia Mental Health Institute, April, 1983

Two patients were 10-20 years old; 24 were 20-30; 18 were 30-40; 35 were 40-50; 17 were 50-60; three were 60-70; and one was more than 70 years old.

First use of alcohol began in one patient at 1 year of age — his father put beer in his bottle feeding. Three began substance abuse between 5 and 10 years of age; 25 between 10 and 15 years of age; 44 between 15 and 20 years of age; 11 between 20 and 25; four between 25 and 30; and four began over 30 years of age. These data were not available for eight patients.

Laboratory evidence of liver damage was found in

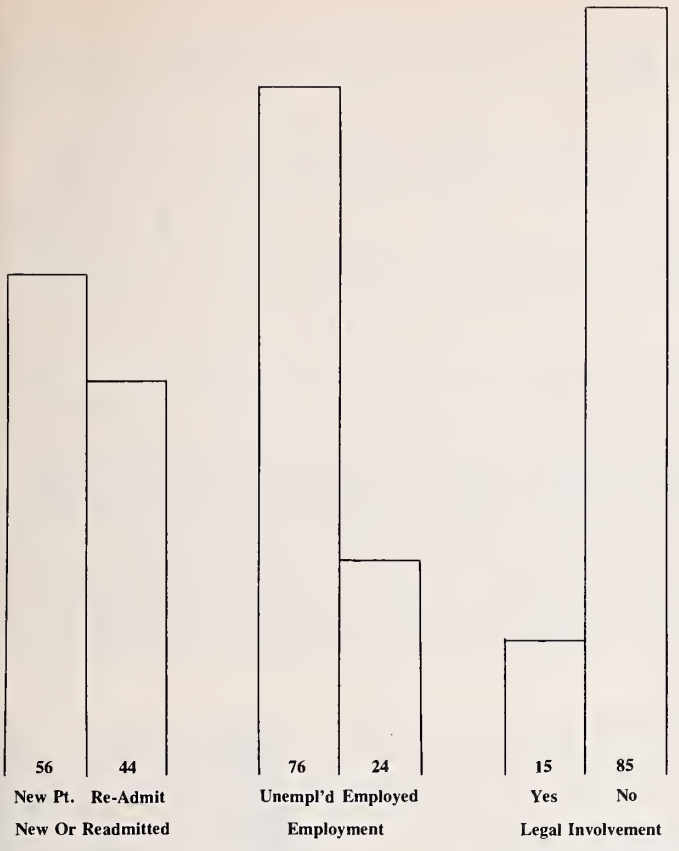


Figure 5 — 100 Patients, by Admission, Employment, and Legal Involvement, Georgia Mental Health Institute, April, 1983



Figure 6 — 100 Patients, by Laboratory Results and Other Diseases, Georgia Mental Health Institute, April, 1983

67 patients, or two-thirds of the group; tests were not available in five patients. Macrocytic anemia was detected in 10 patients. Figures for macrocytosis without anemia were not obtained. Other diseases were found in 46 patients. Twenty-four of these were central nervous system disease, neurologic or psychiatric; 22 were other diseases such as hypertension or peptic ulcer.

Referrals were made from the mental health centers in 63 instances; from DeKalb Emergency Services in 10 instances; from the Probate Court on affidavits in eight instances; and from other varied sources such as hospital emergency rooms in 19 instances.

A routine phenobarbital detoxification regimen was used in 56 of these patients; augmented phenobarbital regimen was used in 30; and medication was not required in 13 patients. One opioid-dependent patient was detoxified with a methadon detoxification regimen.

Twenty patients out of the 100 followed up with the mental health centers at 30 days. Fifty-one who had been referred from that source did not follow up at 30 days; and no reliable information on follow up at 30 days was obtained on 29 patients.

Conclusions

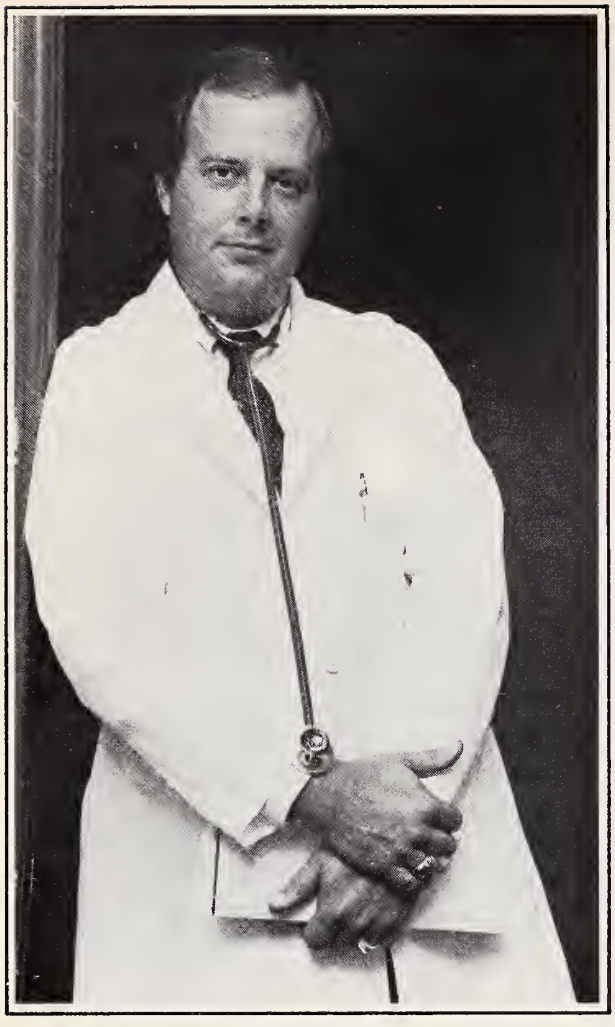
Certain conclusions appear justified for this group of patients; others are suggested by the figures. Care must be exercised in carry-over or generalization to other groups. White males make up the majority of the patients, numbering 63. Alcohol dependence is the predominant addiction in the group. Nearly one-third of all patients showed a problem of mixed dependence involving alcohol and other drugs, indicating the extent to which alcohol may substitute for drugs or vice versa.

Three-fourths of the hundred were unemployed, despite the wide variations in ages; this suggests a high association between addictive disease and failure to be employed. Fifty-four patients were either divorced or separated; again the high association of addictive disease with increased marital stress is suggested.

First use of alcohol or drugs began very early in many of these patients. Eighty-four had begun their use before 25 years of age. This suggests that corrective action and education must be earlier and more effective if the rate of addiction is to be lowered.

Liver damage was detected in two-thirds of the patients, or 67, indicating the high rate of liver pathology, especially in alcoholics. Macrocytic anemia was found in 10 patients.

Figures obtained for follow-up indicate that only a minority of patients followed through with a program of sobriety at 30 days. Ratio of improvement may be somewhat more optimistic than this, since follow up was not obtained on some patients.



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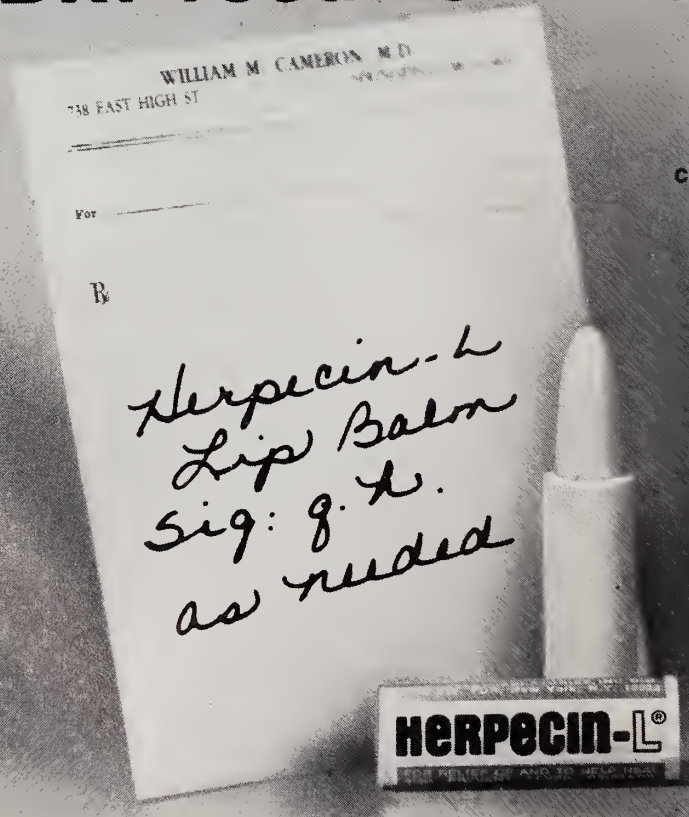


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By utilizing the advances in treatment modalities, pituitary adenomas can be treated with a high success rate and minimal morbidity.

Management of Pituitary Adenomas

DANIEL L. BARROW, M.D., SUZIE C. TINDALL, M.D., and GEORGE T. TINDALL, M.D., *Atlanta**

PROGRESS IN NEUROSURGERY, neuroradiology, neuroendocrinology, and neuropharmacology has changed the diagnostic and therapeutic approach to patients with pituitary disorders. Because of these rapid advances, periodic assessments of management must be made to increase the accuracy of diagnosis, minimize patient risk and cost, and utilize available treatment options appropriately. The widespread employment of computerized tomography (CT) has obviated the need for most other neurodiagnostic procedures. The advent of the dopamine agonist, bromocriptine, has had a major influence in the treatment of human growth-hormone (hGH) and prolactin producing tumors both as primary and adjunctive therapy. In the area of neurosurgery, the refinement of microsurgical techniques has made transsphenoidal surgery the procedure of choice for the vast majority of pituitary neoplasms, including those large lesions producing mass effect. In this article, we will discuss the importance of these advances in current management of pituitary tumors.

Pathology

Classically, pituitary tumors are identified histologically as chromophobe, acidophil or basophil, and mixed adenomas depending on their staining characteristics with hematoxylin and eosin (H & E). Though attempts have been made to correlate secretory characteristics of the tumor with its H & E pathology, this correlation is not reliable. Over the past several years, the introduction of radioimmunoassay, electron microscopy, and immunocytochemistry have permitted closer study of the pathology of pituitary adenomas. Kovacs and Horvath[1] have developed one of the more practical classifications. Their classification, which is based primarily on cytogenesis, attempts to correlate the morphologic features of the tumor cells with their secretory activities, the clinical history, symptomatology, and biochemical findings.

Pituitary tumors are divided according to their size into (1) microadenomas which are tumors < 10 mm in greatest diameter; and (2) macroadenomas which are tumors > 10 mm in greatest diameter. We believe that a third category, the invasive adenoma, should be recognized. This group will include all tumors that invade the cavernous sinus, middle fossa, or walls of the third ventricle, and are therefore unresectable.

Clinical Features

Pituitary tumors generally present with clinical findings related to endocrinopathy or mass effect.

Endocrinopathy results from excessive hormone secretion by a pituitary adenoma. The most commonly encountered clinical syndromes resulting from such endocrine-secreting pituitary tumors are (1) Forbes-Albright syndrome (amenorrhea-galactorrhea) due to hyperprolactinemia; (2) acromegaly due to excessive hGH; and (3) Cushing's disease resulting from excess ACTH and associated hypercortisolism. Even very small functional adenomas may secrete hormones in such excess as to cause profound clinical features or physical changes in a patient.

Endocrinopathy of Prolactin-secreting Adenomas

Because an elevated serum prolactin level is not always associated with major morbidity, prolactin-secreting tumors were considered rare prior to the availability of radioimmunologic serum prolactin

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assays. However, it is now known that prolactinomas are the most common hyperfunctional pituitary tumors, accounting for approximately 25% of all pituitary neoplasms. The exact incidence of prolactinomas is unknown as is the natural history of the neoplasm.

While several different conditions can cause hyperprolactinemia, in practice, the three most commonly identifiable are: ingestion of certain drugs, particularly phenothiazines; primary hypothyroidism; and pituitary tumors.

Endocrinopathy of ACTH-secreting Adenomas

The clinical features of Cushing's disease include "moon facies," "buffalo hump," hypertension, thin skin, purple striae, ecchymoses, osteoporosis, glucose intolerance, emotional disorders, and, in women, amenorrhea and hirsutism. Cushing's disease poses a serious threat to an individual's health and life expectancy. Death results from pyogenic infections, hypertensive-arteriosclerotic cardiovascular disease, or suicide in those patients who are emotionally labile.[2]

Nelson's syndrome results from a pituitary adenoma that develops in a patient who has undergone bilateral adrenalectomy for Cushing's disease.[3] These tumors are usually biologically aggressive. Because a part of the ACTH molecule is similar or identical to melanocyte-stimulating hormone (MSH), the extremely high ACTH levels in these patients results in deep skin pigmentation.

Endocrinopathy of hGH-secreting Adenomas

Excessive growth hormone in the adult produces a syndrome characterized by overgrowth of the hands, head, and feet (especially thickening of the heel pads), prognathism, arthritic manifestations, acroparesthesia (including carpal tunnel syndrome), glucose intolerance with clinically manifest diabetes mellitus in 10-15% of patients, cardiomyopathy, and hyperhidrosis. Acromegaly reduces life expectancy by at least 5 years, most early deaths resulting from arteriosclerotic heart disease.[4]

Mass Effect

Any type of pituitary neoplasm may grow to such a size that it produces symptoms from its mass irrespective of its endocrine characteristics. Most of these tumors are hormonally inactive, allowing them to increase in size without manifesting themselves early as an endocrinopathy. The exception to this is the prolactinoma in the male. Mass effects are most commonly expressed by disturbances in visual acuity, visual field defects, headaches, cranial nerve palsies, hypopituitarism and, rarely, hypothalamic dysfunction or obstructive hydrocephalus. The visual field defect produced by a pituitary tumor typically affects the superior temporal quadrants initially, followed thereafter by the inferior temporal quadrants to produce the characteristic bitemporal hemianopsia.[5] Headaches from pituitary tumors are believed to result from stretching of the diaphragm sellae which is innervated by the ophthalmic division of the trigeminal nerve (V). These headaches may be retroorbital, bifrontal, and/or bitemporal. Pituitary insufficiency results from compression of the gland by the neoplasm and is manifested as loss of libido, skin pallor, loss of pubic and axillary hair, and easy fatigability. A relatively rare manifestation of pituitary tumors is pituitary apoplexy resulting from either hemorrhage into or infarction of the neoplasm. This clinical emergency is characterized by severe headaches, altered mental status, meningismus, acute visual impairment, and oculomotor palsies.

Diagnostic Evaluation

The diagnostic workup of a suspected pituitary tumor consists basically of endocrine testing and neuroradiologic evaluation.

Endocrine Evaluation

We routinely test the integrity of the three anterior pituitary-end organ axes. An outline of values tested for pituitary-gonadal, -thyroidal and -adrenal axes is presented in Table 1. Fasting levels of serum prolactin, hGH, and plasma ACTH should be obtained in patients suspected of harboring secretory tumors.

1. Prolactin-secreting Adenomas

The issue of hyperprolactinemia associated with a pituitary tumor is more complex than it initially appears. Unlike that of other anterior pituitary hormones, hypothalamic modulation of prolactin is predominantly one of inhibition. A prolactin inhibitory factor (PIF) required to prevent an unrestrained release of prolactin by the adenohypophysis has been demonstrated in hypothalamic extracts but has not been purified and characterized. There is some evidence that dopamine is the naturally occurring PIF. Thus, pituitary stalk section or certain hypothalamic lesions that interfere with the normal delivery of PIF to the anterior lobe increase serum prolactin. The prolactin inhibitory mechanism is mediated by the hypothalamic catecholamines, dopamine, and norepinephrine and blocked by dopaminergic-blocking agents such as phenothiazines, tricyclic antidepressants, methyldopa, and reserpine.

In patients with pituitary tumors, it is frequently difficult to identify the underlying mechanisms for elevated prolactin levels when the values are only moderately elevated (that is, < 150 ng/ml). Elevations of this magnitude in patients with pituitary tumors can result from compression of the stalk and/or hypothalamus and may not represent autonomous secretion by the tumor. Thus, a lesion such as

an intrasellar craniopharyngioma, aneurysm, or a non-functional pituitary adenoma could cause modest elevations of prolactin. On the other hand, whenever the fasting level of prolactin exceeds 150 ng/ml, autonomous secretion of prolactin by a pituitary adenoma is almost a certainty. Very high serum prolactin levels (i.e., > 1000 ng/ml) are believed to indicate that the tumor has extended into the cavernous sinus.[6]

Provocative tests have been utilized to determine prolactin reserve in both prolactin deficiency states and in cases of autonomous prolactin release. While the prolactin response to these provocative tests have been useful in identifying structural lesions in the vicinity of the stalk and gland, these tests have not served to differentiate between the different mechanisms responsible for elevated prolactin levels in patients with pituitary tumors. The response (in serum prolactin levels) to provocative tests is blunted or absent in all these situations. In our opinion, these provocative tests are unnecessary when levels are > 150 ng/ml or when a tumor is identified on CT, as the diagnosis is already made, and the tests would add little to the investigation. When the prolactin levels are mildly elevated and the CT scan is equivocal or nondiagnostic, the usefulness of provocative tests is greater.

2. ACTH-secreting Adenomas

Cushing's syndrome is the result of hypercortisolism of any cause. This results from a pituitary adenoma secreting excessive ACTH in about 75% of patients and is referred to as Cushing's disease. About 24% of patients with Cushing's syndrome will harbor a primary adrenal tumor, either an adenoma or carcinoma secreting excess cortisol. Less than 1% of patients with the syndrome will have a tumor outside the adrenal or hypothalamic-pituitary area secreting excessive ACTH, usually a lung carcinoma.[7] The low- and high-dose dexamethasone suppression tests and the metyrapone test are useful in the diagnosis of patients with Cushing's syndrome and in selecting those with pituitary tumors (Cushing's disease). For details of these tests and the significance of their results, the reader is referred to standard texts of endocrinology. The usual findings in patients with Cushing's disease (pituitary ACTH secreting adenoma) include:

—no suppression of A.M. cortisol by low-dose dexamethasone
—suppression with high-dose dexamethasone
—stimulation of ACTH secretion and 17-hydroxycorticosteroid level after metyrapone.

3. hGH-secreting Adenomas

In addition to the tests outlined in Table 1, patients known to have or suspected of having acromegaly

TABLE 1 — Endocrine Tests for Pituitary — Target Organ Function

Axis	*Normal Values* *Male*	*Female*
Pituitary — Gonadal		
Serum FSH	2-14 mIU*/ml	5-20 mIU/ml
Serum LH	1-20 mIU/ml	2-30 mIU/ml
Serum Testosterone	300-1,200 ng/100 ml	20-80 ng/100 ml
Serum Estradiol	1-3 ng/100 ml	2-7 ng/100 ml
Pituitary — Thyroidal		
Total T_4	4.5-11.5μg/100 ml	
Free T_4	1.0-2.3 ng/100 ml	
TSH	< 6μU/ml	
Pituitary — Adrenal		
Serum Cortisol	6-18 μg/100 ml	
24-hour urinary 17-ketosteroids	3-24 mg/24 hr.	1-18 mg/24 hr.
17-hydroxycorticosteroids	2.9-12.0 mg/24 hr.	1.1-8.6 mg/24 hr.

* mIU = milli − international unit.

TABLE 2. Indications for Surgery in Patients With Pituitary Tumors

1. Verified prolactinoma causing AG syndrome and infertility in women who desire pregnancy
2. Verified pituitary tumor causing Cushing's disease, Nelson's syndrome, or acromegaly
3. Macroadenoma (particularly with extrasellar extension)
4. Pituitary tumor causing mass effect
 a. Visual loss
 b. Pituitary insufficiency
5. Pituitary tumor associated with pituitary apoplexy

are evaluated with a glucose suppression test. Simultaneous serum hGH and glucose values are obtained before and 30, 60, 120, and 180 minutes after oral administration of 100 gm of glucose. A fasting serum hGH >5 ng/ml with less than 50% reduction at any time following glucose ingestion is considered abnormal and indicative of autonomous growth hormone secretion.

Neuroradiologic Evaluation

The neuroradiologic evaluation of sellar and parasellar pathology has been revolutionized by the advent of high-resolution coronal CT. In our opinion, this is the only neurodiagnostic test required in the vast majority of cases (Figures 1 and 2). The diagnostic accuracy of the scanner, while not perfect, is superior to multidirectional polytomography and pneumoencephalography and thus has replaced these tests. In our opinion, cerebral angiography is not indicated in the neurodiagnostic evaluation, particularly when the patient has a documented endocrinopathy or when the level of serum prolactin is > 150 ng/ml. However, when the level is < 150 ng/ml and there is a possibility of an intracranial aneurysm with intrasellar extension, visualization of the intracranial circulation becomes important. The newer technique of intravenous digital subtraction angiography will confirm or eliminate the diagnosis



Figure 1 — Coronal CT scan showing an 8 mm low density adenoma (arrow) with erosion of the floor of the sella below the tumor

of an aneurysm and avoid the arterial injections of conventional arteriography.

Medical Therapy

Bromocriptine (2-bromo-alpha-ergocryptine), an ergot derivative with dopamine receptor agonist properties, has been used to treat disorders in which there are abnormalities of dopamine synthesis or metabolism and has had an influence on the management of some pituitary tumors. There is continuing controversy over the ideal method of therapy for prolactinomas since both medical (e.g., bromocriptine) and surgical (e.g., transsphenoidal microsurgery) treatment provides either effective control or cure in a majority of cases. Significant shrinkage of prolactin-secreting pituitary tumors (prolactinomas) following administration of bromocriptine has been demonstrated in several relatively recent publications.[9, 10] The pathologic basis for these changes has been shown to be due to involution of adenomatous prolactin cells with reduction in cytoplasmic, nuclear, and nucleolar areas.[10, 11] However, the drug does not have a cytotoxic effect and thus does not eradicate the tumor. Therefore, discontinuation of bromocriptine in patients with responsive prolactinomas is followed by a relatively quick return of the tumor to its pretreatment size.[9, 10, 12]

Because of the structural changes induced by bromocriptine, it seems appropriate to use the drug as preoperative treatment in an effort to achieve shrinkage of the tumor, a favorable change that we reason may make excision of the tumor not only easier but possibly more successful. Our early experience with the use of bromocriptine as a preoperative adjunct indicates that the tumors are not only smaller but also softer and easier to remove with suction. The pathologic changes which reveal degenerative effects of the drug substantiate the gross observations. However, Landolt et al[13] have recently reported that the use of bromocriptine may actually reduce the chance of a surgical cure should one choose the latter option after treatment with bromocriptine. The issue of preoperative treatment of prolactinomas with bromocriptine will require further investigation. Although short-term treatment causes shrinkage of the tumor, long-term treatment may induce a fibrosis that makes surgical excision more difficult.

Patients with persistent postoperative hyperprolactinemia who continue to have amenorrhea and galactorrhea on the basis of disruption of PIF pathways are good candidates for medical treatment with bromocriptine. Therapy with bromocriptine is also an alternative option to radiation therapy or reoperation in the patient with a proven recurrent prolactinoma in whom total surgical excision is not possible.

Other series have reported a beneficial effect from bromocriptine in patients with pituitary tumors other than prolactinomas. In two larger series of

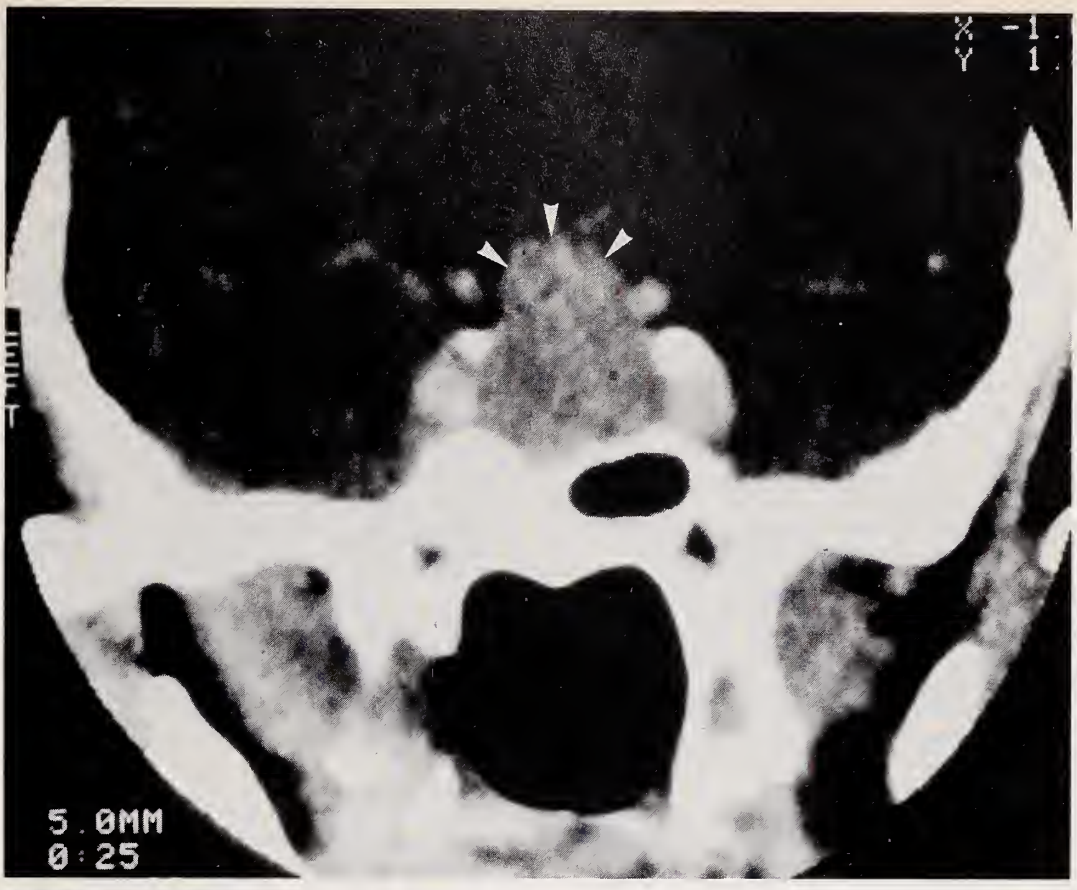


Figure 2 — Coronal CT scan of a macroadenoma with extension into the suprasellar cistern (arrow)

acromegalics, 73 patients were treated for 3-25 months, with 97% showing symptomatic and clinical improvement and 79% having significant reduction of hGH levels.[14, 15] Less dramatic results have been observed in patients with Nelson's or Cushing's disease even though suppression of both pituitary ACTH levels[16] and the level of circulating steroids[17] have been reported after bromocriptine treatment.

About 60% of patients with Cushing's disease or Nelson's syndrome will have a clinical or biochemical response to cyproheptadine, a serotonin antagonist that has been used as medical treatment for these disorders.[18] Once the drug is discontinued, however, the symptoms recur, and some patients relapse under treatment. The most prominent side effect of treatment with cyproheptadine is drowsiness. This sometimes lessens with continued use of the drug. Less frequent effects include dry mouth, anorexia, nausea, dizziness, and with higher dosages, confusion and ataxia. We reserve the use of this drug and radiotherapy for those patients too ill to undergo surgery, or occasionally for those with residual or recurrent tumor.

Some investigators have used bromocriptine to treat acromegaly,[13, 14, 19-21] but a dosage larger than that used in prolactinomas is required. Even then, hGH levels are often not restored to normal, and the tumor is not eradicated. Radiotherapy, particularly proton beam radiation, has its advocates.[22] We reserve medical and radiation treatment for residual or recurrent tumor following an attempt at surgical cure.

Surgical Treatment

Currently, transsphenoidal microsurgery is the most appropriate surgical procedure for the vast majority of pituitary tumors. The technical details of the exposure along the nasal septum, entry into the sphenoid sinus and floor of the sella turcica, and the method of tumor removal have been well covered in other publications.[23] The surgical procedure is performed through an incision in the gingival mucosa under the upper lip. Removal of the anterior wall of the sphenoid sinus exposes the floor of the sella turcica. The microscope is an absolute necessity for the performance of this surgery, particularly in identifying and excising microadenomas and preserving the normal pituitary gland.

The indications for surgery in patients with all pituitary tumors at our institution are shown in Table 2. Transsphenoidal microsurgery is a reasonable choice for women with a verified prolactinoma causing the amenorrhea-galactorrhea (AG) syndrome and who desire pregnancy. The majority of these cases will have microadenomas, and it is in this group that surgery achieves the best results. The macroadenoma, particularly with suprasellar exten-

sion, should, in our opinion, be surgically removed. The lesion has already demonstrated that it has growth potential and, while medical therapy has been demonstrated to shrink the lesion, it nevertheless does not eradicate it. Surgery, therefore, remains the only method with a reasonable chance for cure. The initial treatment of choice for Cushing's disease is transsphenoidal microsurgery. If patients meet the diagnostic criteria for the disease, a pituitary adenoma will usually be found. The majority of these tumors are microadenomas. The results of transsphenoidal surgery are good, with a cure rate on the order of 75-80%.[24] In patients in whom a distinct adenoma is not identified, or when there is recurrence of disease after transsphenoidal surgery, a complete hypophysectomy is recommended.

Surgical therapy should be the first treatment option in acromegaly. In our experience, 70% of patients with acromegaly will be cured following transsphenoidal surgery. Reoperation has not been shown to be beneficial in our patients with recurrent tumors.

Pituitary tumors causing mass effect, especially those producing visual loss, should undergo surgery without delay. Tumors that are associated with pituitary apoplexy, while rare, should be operated upon as an emergency.

Low operative mortality rates and the ability to remove tumor and spare the normal pituitary gland in the majority of patients are the primary advantages of modern transsphenoidal microsurgery. This operative approach is recommended in all patients with pituitary tumors in whom operation is indicated, except in the following circumstances:

(1) Extrasellar extension of the tumor into the anterior and/or middle fossa as determined by CT scan or other reliable neurodiagnostic tests. On the other hand, suprasellar extension of tumor directly above the sella turcica, even in cases where the extrasellar extension reaches 2 to 3 cm, can be managed by the transsphenoidal technique.

(2) Presence of a suprasellar tumor with a normal or only slightly abnormal sella turcica. This is likely to be the unusual "collar-button" type extension in which the tumor extends through a relatively small opening in the diaphragm sella and then expands into a larger suprasellar component. In both the above situations, the lesion is best exposed and managed by craniotomy.

Results and Complications of Surgery

Tables 3, 4, and 5 summarize the incidence of transsphenoidal microsurgery to cure the endocrinopathy associated with pituitary tumors.

The potential effect of transsphenoidal surgery on pituitary endocrine function is an important consideration. To determine this effect, we performed

TABLE 3 — Incidence of Transsphenoidal Adenomectomy to Cure Endocrinopathy in Prolactinoma

Series		*No. of Patients Treated*	*No. of Cures*
Chang et al[25]*	Prolactinoma<1cm	18	16(89%)
	Prolactinoma>1 cm	7	2(29%)
Hardy et al[26]†	Preoperative PRL<200 ng/ml	53	48(91%)
	Preoperative PRL>200 ng/ml	27	11(41%)
Faria and Tindall[27]†	Preoperative PRL<200 ng/ml	72	55(76%)
	Preoperative PRL>200 ng/ml	28	13(46%)
Post et al[28]†		30	21(70%)
Aubourg et al[29]†		90	39(44%)
Dominque et al[30]*		91	62(68%)

* Criteria of cure: return of normal menses.
† Criteria of cure: reduction of postoperative prolactin level to normal (25-30 ng/ml).

TABLE 4 — Incidence of Transsphenoidal Adenomectomy to Cure Endocrinopathy of Cushing's Disease

Series	*No. of Patients Treated*	*No. of Cures*
Tyrrell et al[31] and Wilson[32]	72	59(82%)
Salassa et al[33]	18	16(89%)
Wilson et al[24]* (Nelson's disease)	19	4(21%)

* Criteria of cure: reduction of postoperative ACTH levels to normal.

TABLE 5 — Incidence of Transsphenoidal Adenomectomy to Cure Endocrinopathy in Acromegaly

Series	*No. of Patients Treated*	*No. of Cures*
Hardy and Somma[34]*	120	94(79%)
Laws et al[35]†	80	53(66%)
Arafab et al[36]†	28	17(61%)
Tucker et al[37]*	32	24(75%)
Wilson[32]†	137	99(72%)
Ludecke et al[38]*	80	70(87%)

* Criteria of cure: reduction of hGH level to 5 ng/ml or less.
† Criteria of cure: reduction of hGH level to 10 ng/ml or less.

complete endocrine tests before and 10 days following transsphenoidal surgery on 97 women with prolactinomas — 70 women (72%) had microadenomas. The results of the study are shown in Table 6. One can conclude from these data that approximately 7% (i.e., 7 out of 97) will experience damage to one or more pituitary-target organ axes as a sequela to transsphenoidal surgery performed by an experienced surgeon.

Patients and endocrinologists often question the safety of transsphenoidal microsurgery. In an effort to provide an answer, several neurosurgeons with considerable transsphenoidal experience were polled as to the mortality and morbidity rates in their series. Any patient that died within 30 days of

TABLE 6 — Preoperative and Postoperative Endocrine Values*

Normal:	Preoperative	65
	Normal postoperative	50
	Deficit in 1 cm or more axes, temporary	10
	Deficit in 1 cm or more axes, permanent	5
Abnormal:	Preoperative (i.e., deficit in 1 or more axes)	32
	Improvement postoperative	11
	No change postoperative	19
	Worse postoperative	2

* Based on 97 cases, with complete preoperative and postoperative studies.

TABLE 7 — Mortality and Complication Rate From Transsphenoidal Surgery on Pituitary Tumors*

Series	*No. of Cases*	*No. of Mortalities*	*No. of Cases With Complications*
Collins	410	3	8
Hardy	912	4	19
Wilson	942	2	20
Laws	896	4	28
Tindall	437	1	11
Ciric	290	0	6
Weiss	559	2	4
van Gilder	430	3	14
Total	4,876	19(0.4%)	110(2.3%)

* Includes all adenomas (functional and nonfunctional microadenomas and macroadenomas). These data were obtained in June 1982.

surgery was counted as an operative mortality. Complications included CSF rhinorrhea that required reoperation (i.e., leaks that did not stop spontaneously or following one or more lumbar punctures), meningitis, and nonfatal arterial injury. The data obtained from a total of eight neurosurgeons included all pituitary tumor surgery and excluded hypophysectomies. The results of the poll are shown in Table 7. A total of 4,876 transsphenoidal operations were performed by these eight surgeons, with an operative mortality of only 0.4%. In the group of 19 patients who died as a result of or in association with the operation, there were extenuating circumstances in nearly every case. For instance, some patients had undergone previous therapies, such as craniotomy, had extremely large tumors, were in marginal health status, etc. It is significant that none of the eight neurosurgeons had an operative mortality in a patient with a microadenoma. The complication rate of only 2.3%, or 110 cases in the total of 4,876 operations, is acceptably low.

Summary

Significant morbidity may result from pituitary adenomas of relatively small size. A modern approach to these fascinating neoplasms can result in dramatic resolution of clinical symptoms and signs. By appropriately utilizing the diagnostic tools of endocrinology and neuroradiology, transsphenoidal microsurgery, and properly selected adjunctive therapies, the treatment of pituitary adenomas can be accomplished with a high success rate and minimal morbidity.

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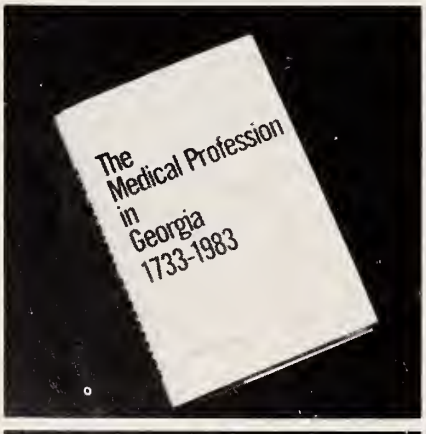
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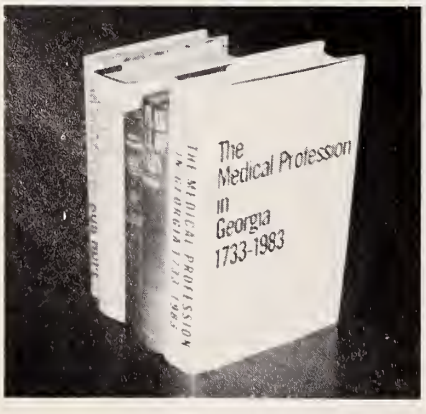
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Central nervous system disturbances such as confusion, agitation, and mental obtundation are early clues to diagnosis.

Acute Water Intoxication Complicating Transurethral Resection of the Prostate

JAMES O. DAY, M.D., *Griffin**

Abstract

Acute water intoxication is a rare complication of transurethral resection of the prostate. Two patients in whom this complication developed are discussed. Factors influencing absorption of bladder irrigating fluids include duration and extent of the resection and overfilling of the bladder. After recognition, treatment consists of administration of hypertonic saline in combination with furosemide. Early recognition of this potential complication may further reduce this procedure's already low morbidity and mortality.

Hyponatremia has been well documented in the urology literature as a rare complication of transurethral resection of the prostate. Severe water intoxication can occur and has been attributed to absorption of irrigating fluids during the resection. It is rarely mentioned, however, in the general medical literature as a potential cause of water intoxication. For this reason, it may be particularly unfamiliar to the medical consultant who sees the patient. Two patients who developed this complication after use of 1.5% glycine irrigation fluid are presented here.

Case 1

A 72-year-old white man was admitted to the urology service with recent onset of painless hematuria. There was a history of nephrolithiasis 20 years ago, but no other serious problems.

Physical examination revealed blood pressure 118/70, pulse rate 80 beats/min., temperature 98.6°F., and respiratory rate 20/min. Head and neck were not remarkable. Breath sounds were diminished bilaterally. Heart rhythm was regular without murmurs. Abdomen was not remarkable except for a right inguinal hernia. Rectal examination revealed an enlarged prostate estimated at 20 gm. size.

Chest x-ray showed findings of obstructive lung disease, and the electrocardiogram was normal. Intravenous pyelogram was normal except for a postvoid residual urine. Blood chemistries showed sodium 145 meq./L., potassium 4.1 meq./L., carbon dioxide 29 meq./L., chloride 104 meq./L., blood sugar 101 mg.%, BUN 14 mg.%, and creatinine 1.0 mg.%. Complete blood count revealed hematocrit 45%, white blood cell count 6200 with a normal differential count. Urinalysis showed specific gravity 1.017, 3+ occult blood, 10-20 red blood cells per high powered field.

Cystoscopy was performed and confirmed prostatic enlargement. Bilateral retrograde pyelograms were normal. At the time of transurethral prostatic resection, considerable bleeding was encountered. This necessitated the use of large volumes of bladder irrigant. Post-operatively, the patient became confused and lethargic. Serum electrolytes showed a serum sodium 101 meq./L., potassium 2.9 meq./L., chloride 72 meq./L., carbon dioxide 24 meq./L., and hematocrit was 32%.

The patient was treated with 5% hypertonic

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saline, isotonic saline, potassium supplement, and 2 units of packed cells. Acute pulmonary edema developed and improved with oxygen, furosemide, and temporary mechanical ventilatory support.

At 12 hours after surgery, serum sodium had increased to 124 meq./L. and at 24 hours, 133 meq./L. Seventy-two hours after surgery, serum sodium was 143 meq./L. The remainder of his hospital course was uneventful, and he was discharged a few days later.

Case 2

An 81-year-old black man was admitted with acute urinary retention. There was a history of an old cerebrovascular accident without residual deficit and no other serious past medical problems.

Physical examination revealed blood pressure 130/60, pulse rate 64 beats/min., respiratory rate 16/min., and temperature 98.6°F. Pertinent findings included a hypersensitive carotid sinus producing transient bradycardia on palpation. There was a grade I systolic ejection murmur. Prostate was enlarged and estimated at 10 gm. size. Otherwise, the physical examination was not remarkable.

Laboratory data showed a serum sodium 139 meq./L., potassium 4.6 meq./L., carbon dioxide 21 meq./L., chloride 110 meq./L., BUN 25 mg.%, creatinine 1.9 mg.%, hematocrit 36.6%, and acid phosphatase 0.4 μ/ml. (Normal 0.1-0.7 μ/ml.). Urinalysis revealed a specific gravity 1.016, 2+ occult blood, 15-20 white blood cells, and 10-12 red blood cells per high powered field. Urine culture was negative. Chest x-ray showed an old calcified right hilar lymph node but was otherwise normal. Electrocardiogram was normal. Intravenous pyelogram showed marked bladder wall thickening, multiple diverticuli, and trabeculations.

On the third hospital day, transurethral resection prostatectomy was performed under low spinal anesthesia. A small amount of extravasation complicated surgery. Immediately post-operatively, the patient became lethargic and somnolent.

Serum electrolytes revealed serum sodium 107 meq./L., potassium 4.1 meq./L., carbon dioxide 19 meq./L., and chloride 89 meq./L. He was treated with 500 cc 3% hypertonic saline, followed by isotonic saline 1000 cc per 8 hours. Furosemide was given concurrently. After 4 hours, serum sodium had increased to 125 meq./L. and at 24 hours, 126 meq./L. At 48 hours, serum sodium was 136 meq./L., potassium 4.3 meq./L., chloride 106 meq./L., carbon dioxide 24 meq./L., BUN 19 mg.%, and creatinine 1.6 mg.%. On the second post-operative day a cystogram confirmed some extravasation which was removed under local anesthesia by incision and drainage. Over the 48 hours after surgery, the patient's confusion and lethargy resolved.

On the sixth post-operative day, the patient experienced aphasia, right facial weakness and right hemiparesis consistent with a cerebrovascular accident. He became comatose and died one day later.

Discussion

The problem of acute water intoxication due to absorption of bladder irrigating fluid during transurethral resection has been known for many years. It has been described after the use of distilled water and less commonly after the use of isotonic fluids such as glycine solution.[1, 2]

Radioisotopic techniques have been used to study fluid absorption during transurethral resection. Oester and Madsen reported that 29% of the irrigation fluid was absorbed directly into exposed venous sinuses, and the remainder was absorbed extravascularly.[3] Other authors have reported a significant loss of sodium into the irrigating solutions as well.[4] The amount of fluid absorption correlates well with the extent and duration of resection and the number of open sinuses. Marx and Orkin have suggested that keeping the duration of surgery to less than 1 hour may be safe if the resection is not extended deep into the sinuses of the capsule.[5] It has also been suggested that the surgeon avoid overfilling the bladder, since this increases hydrostatic pressure in the prostatic fossa which forces fluid into exposed veins.[2, 4]

Central nervous system disturbances such as confusion, agitation, and mental obtundation are early clues to diagnosis. The signs of hyponatremic encephalopathy are usually not manifest until the serum sodium is depressed to 120 meq./L. or less. These symptoms are felt to be due to intracellular movement of water resulting in cerebral edema.

Treatment generally consists of administration of hypertonic saline, sometimes in combination with furosemide. Some authors have also suggested using sodium bicarbonate if hypertonic saline is not readily available.[2]

Transurethral resection of the prostate is a safe procedure with a low morbidity and mortality.[6] It is hoped that early recognition of this potential complication may result in an even further reduction in morbidity and mortality.

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A Life-Saving Holiday Motto

THROUGH THE MEDIA of television, the American physician in the afternoon soaps is a seductive macho adventurer, a happy-go-lucky surgeon in the afternoon's "MASH," a clever detective pathologist in the evening "Quincy." In truth we are none of these, yet part of all of them, while in fact they reflect the immense interest the American public has in the physician.

In that role, we can play a critical and often life-saving function as this holiday season approaches. Reveling, partying, and drinking are part of the yuletide festivities. We know that alcohol is a sedative hypnotic drug; we know that alcohol minus water equals ether. We know that experimental and clinical evidence indicate that after drinking there is decreased depth perception, abnormally slow reflex reaction, and distorted judgmental thinking — all contributors to death and carnage on the highways.

However, it is not necessary to have a drink to have a good time. From an addictionologist's standpoint, if you have to have a drink to socialize, that is not social drinking.

To many, it will make a significant impact if the physician this holiday season at a party simply says:

"No thank you, I don't want a drink, since I'm driving."

This simple motto could be life saving if enough physicians repeated it enough times for enough people to hear at enough holiday parties. The American health model and modeler has spoken.

G. Douglas Talbott, M.D.
Internal Medicine/Addictionology
Smyrna

A Medical Revolution

THERE IS AN UPHEAVAL occurring in the practice of medicine today which jeopardizes the medical care you deliver. This upheaval is comparable to the Industrial Revolution of the last century, for its effects are equally profound. Medicine began as a profession unfettered by regulation, but along with everyone else we have been subjected to more and more controls as our society has grown in complexity. The regulatory effort was developed for the perceived good of all but now has become a threat to continued quality care.

As the practice of medicine came of age around the turn of the century, our predecessors saw the need for the profession to have a stronger scientific foundation. Improved educational requirements and facilities were perceived as mandatory, and following the Flexner study of medical education in 1910, our profession turned the corner on medical education. The ensuing 70 years saw a revolution in technology and, more recently, in access and quality of care as our society invested

even more resources in health research, education, and care. Today, the United States health care system is the "gold standard" for the world. The cost for this standard, however, is high — 10.5% of the gross national product (GNP). With these developments, changes in the demographics of the system have occurred which are destined to play a major role in the health care of the future.

A major and carefully documented change has been the increasing age and medical care requirements of our population. Average life expectancy has increased from 47 years in 1900 to 74 years in 1983. As the percent of our population 65 or older reached 11% last year, we spent 33% of our total health budget on their health needs. This trend will certainly continue.

Equally impressive has been the change in our hospitals. We now have 7000 acute care hospitals built on the crest of federal legislation which subsidized hospital construction. As the number increased, the occupancy rate fell, with inevitable financial problems. There has been a large influx of investment capital into the construction or purchase of hospitals by large health service corporations, until today nearly 1000 of the hospitals in the U.S. are privately owned, "for profit" institutions. Many of the remaining community hospitals have joined together in "Multi Hospital Systems" for economic survival. They are also actively searching for means of increasing their cash flow to offset losses from more stringent utilization review, outpatient surgery, and earlier use of home health services.

Hospitals in our country today are staffed with extremely well trained people — from the administrator, who likely has an M.B.A., to the "new breed" of medical record librarian. Our nurses are better qualified and educated; they staff our complex intensive care units, as well as perform more traditional floor duty. The administrative staff must be experts in health, finance, computers, negotiations, and regulations. In addition, the multitude of technical workers have each improved their status by additional educational requirements and often certification.

As the patients and hospitals are different, so are the physicians. We have had mushrooming growth in the numbers of medical students, residents, and private physicians. The number of students has more than doubled in the past 12 years and, in addition, we still admit a limited number of foreign medical graduates. These students are largely from the 22 Caribbean schools but can be from any of 900 medical schools worldwide. We have far greater numbers of female physicians (12%) and female medical students (33%) than in the past. We are also producing more primary care doctors as well as more specialists of all sorts.

The product we deliver today would be almost unrecognizable to our colleagues of just 20-25 years ago. Our drugs, diagnostic equipment, adjunctive services, and equipment are very expensive, but with their aid the quality of care is spectacular. Advances such as the development of the polio vaccine have emptied large state hospitals. With more precise diagnoses, we are able to treat successfully, either medically or surgically, diseases which in the past were devastating. Use of the renal dialysis program has risen from 9000 patients per year in 1972 to 48,000 in 1980!

The cost of this improved quality, 10.5% of the GNP, is nearly double the resources devoted to health care in Great Britain and by its size has attracted some of the largest corporate investors as participants. With such large amounts of money involved, the construction of facilities and their subsequent operation, the provision of equipment and supplies, and today finally the corporate direct provision of health care are fair game for these corporations. This development has been aided by legislative, administrative, and judicial actions aimed at increasing competition in our health care delivery system.

Society has grown increasingly aware of the high cost of health care. Individuals have watched their insurance costs double and then triple in a very short time, and business has seen its budget for health care in many cases outstrip the cost of raw materials it uses in production! A simultaneous development has been the large increase in the number of physicians finishing the educational process each year.

These new physicians have had to borrow an increasing amount of money during their training, starting practice in 1983 with an average debt of over $18,000. (This figure is increasing annually.)

Faced with the pressure for debt repayment, fulfillment of their own ambition, and the marked increase in competition, many young physicians find the answer to their problems in working for "someone else." The luxury of going into solo practice seems unobtainable to most. More of these graduates will join group practices which have increased from 1.2% of all physicians in 1940 to 25% in 1980. More of them will accept salaried positions with prepaid health care plans and more will accept employment by corporations which set up primary care facilities in shopping malls.

Congress has come under increasing pressure in recent years to "do something" about health care costs. The federal government reacted with a "freeze," then attempted a "cap," all the while vigorously pursuing the use of tight utilization review control. These measures were inadequate solutions to a complex problem. A more drastic step has been taken which significantly alters the manner in which the government will pay for hospital care of the elderly. Incentives are in place with this new system to reduce resources used in the care of the elderly. This will require the best efforts of the hospital medical staff and administration to accomplish with no adverse effects on quality.

My responsibility as the primary advocate for my patient has grown in complexity as pressures from all sides strive to limit health resources devoted to his or her care. I must be certain that the federal government's efforts at cost containment with the Prospective Pricing System and DRGs do not adversely affect my patients. I must also be certain that prepaid private health plans do not eliminate necessary medical care while concentrating on efficiency and economy. As industry develops its own plans or participates in those developed by others, the same necessity is present; as the "delivery systems" grow larger, they also grow harder to manage!

This task is impossible for me to perform alone. I must join with my colleagues or fail in the task of assuring quality medical care for the American public. It is imperative that rural and urban, young and old, male and female physicians, as well as those in solo or group practice, look at the problems and provide reasonable answers. It is also mandatory that the academic community participate in this effort and not remain in their "ivory tower." The problems associated with the revolution I describe are so complex and the magnitude so great that solutions will tax even our collective capabilities.

The vehicle for such collective action exists in our county and state societies and the American Medical Association. Within the A.M.A., an innovative approach to the solution of our problems was made by the decision of the A.M.A. House of Delegates to fund the effort known as the "Health Policy Agenda for the American People." This has been a 3-year effort by all health-related organizations in this country to look at the medical needs of our citizens and arrive at the best means of satisfying them. We are to see the first results of this study in 1984. I urge your support of and participation in organized medicine and this effort, for if you and I fail, our patients will suffer.

Harrison L. Rogers, M.D.
General Surgeon, Atlanta
Speaker, AMA House of Delegates



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Antitrust Principles and the Physician-Patient Relationship

ROBERT N. BERG, *Atlanta**

Is a physician under an obligation to render medical care to anyone seeking the physician's services? As early as 1936, a Georgia Court answered this question in the negative, finding that "there is no rule of law that requires a physician to undertake the treatment of every patient who applies to him."[1]

Of course, the general rule that physicians are free to choose the patients they will and will not serve is subject to certain well known exceptions. The physician is under an ethical obligation, for example, to respond to the best of his or her ability in cases of emergency where first aid treatment is essential.[2] Similarly, public hospitals in Georgia which maintain emergency facilities are under a legal obligation to provide emergency treatment to members of the public who present themselves as being in need of such treatment.[3]

Now, judging by a recent opinion rendered by the California Court of Appeal, there may be a different type of exception to this general rule — a medical group comprised of physicians may be required to treat a patient if that group has a monopoly for the provision of health care services in a geographical area. This California case is the subject of this month's "Legal Page."

Refusal to Treat as an Antitrust Violation

The plaintiffs in *Leach v. Drummond Medical Group, Inc.*[4] were a husband and wife residing in Ridgecrest, California. Both of them were ill: The wife had extremely low blood pressure, hypoglycemia, and diabetes, which resulted in periodic blackouts. The husband suffered from a high triglyceride count in his bloodstream for which he was required to take medication on a regular basis; he also required periodic checkups to insure that the medication was working.

In December, 1978, the plaintiffs read a newspaper article which stated that various State of California regulatory agencies were investigating the care available at the emergency room of the Ridgecrest Community Hospital, which was provided by a group of physicians doing business as the Drummond Medical Group, Inc. (the "Medical Group"). Believing that a "health facilities representative" mentioned in the newspaper article had the authority to investigate and correct deficiencies in hospitals and licensed physicians, the plaintiffs wrote to him and described their experiences in the emergency room of the Hospital and also recited the history of treatment of a small child (who was then in the plaintiffs' care) by a specifically named doctor who was a member of the Medical Group. The letter did not, however, contain any allegations regarding the Medical Group.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

Subsequently, the plaintiffs received a letter from the State department charged with the responsibility of regulating hospitals, indicating that the department would investigate the plaintiffs' statements concerning the Hospital. The letter also indicated that a different State agency (the Board of Medical Quality Assurance, a branch of the Department of Consumer Affairs) was the proper agency to investigate reports concerning individual physicians and that the plaintiffs' letter had been referred to that department. Shortly thereafter, the plaintiffs received a letter from the Consumer Affairs Department stating that it was opening an investigation of the physician named in the plaintiffs' letter.

About 6 months later, the wife received a certified letter from the Medical Group, stating that because of the plaintiffs' allegations made to the Consumer Affairs Department, the Medical Group would no longer provide medical services to her or any member of her immediate family. The letter went on to indicate that treatment would be provided on an "emergency only" basis for 30 days from the date of the letter to allow the plaintiff to make arrangements for substitute medical care.

. . . should the physician's duty [to treat a patient] be dependent upon the existence of other physicians in the area?

The refusal by the Medical Group to provide medical services to the plaintiffs created a slight problem, in that, according to the plaintiffs, the nearest medical facility comparable to the Hospital was located approximately 100 miles away. The plaintiffs then sued the Medical Group, seeking an injunction to prohibit them from denying medical care to the plaintiffs as well as damages for the deprivation of such care. Specifically, the plaintiffs raised four separate causes of action: (1) that the Medical Group's refusal to provide treatment violated certain provisions of the California Civil Rights Act; (2) that the refusal constituted unlawful discrimination by a public entity; (3) that the refusal constituted an unlawful interference with the plaintiffs' right to petition their government; and (4) that the refusal constituted an unlawful discrimination by a monopolist under the California common law (the "law" created by judicial decisions, as opposed to enacted by statute).

The trial court, after reviewing the complaint and the defendants' answers, dismissed the plaintiffs' lawsuit for injunctive relief with prejudice (thereby barring the plaintiff from reinstituting the lawsuit with an amended complaint), because the personal nature of the physician-patient relationship precluded the compulsory creation or continuance of that relationship. In the court's view, since the physician-patient relationship is predicated upon trust and confidence, the lack or loss of which would render initiation or continuation of that relationship impossible, the patient could not successfully ask the court to *force* the physician to start or continue treatment. The court also dismissed the plaintiffs' claim for damages, finding that the defendants' actions did not constitute unlawful discrimination or impede the plaintiffs' ability to petition their government.

On appeal, the California Court of Appeal reversed the trial court, finding that the plaintiffs should have been given an opportunity to amend their complaint, in order to allow the plaintiffs to include certain facts which, if established by the evidence, would support a verdict for the plaintiffs. In other words, the Court did not say that the defendants' actions violated the law, but it did say that the plaintiffs should not have been thrown out of court without first being given an opportunity to prove their case.

Specifically, the Court first rejected the trial court's determination that the plaintiffs' request for injunctive relief must be denied on the basis of the nature of the physician-patient relationship. Taking a somewhat constrained view of the facts, the Court suggested that the plaintiffs' complaint "[did] not seek to compel any individual physician either to undertake or continue a personal physician-patient relationship with either of [the plaintiffs]." Rather, the complaint was filed

against the defendant Medical Group, a corporation, which in the Court's view "could be compelled to provide medical services to the plaintiffs without the Court ordering performance of such services by a specific doctor." The Court also found it distressing that, in light of the conditions of the plaintiffs and the resultant potential for severe complications, the "clear and inescapable inference from [the defendants' termination letter] is that after the expiration of thirty (30) days defendants will provide no emergency treatment" to the plaintiffs.

Having determined that the plaintiffs conceivably could have been entitled to the injunctive relief they had sought, the Court then turned to the specific causes of action raised in the complaint. For reasons outside of the scope of this article, the Court decided that the plaintiffs' two causes of action involving unlawful discrimination by a "public" entity should not have been dismissed, while the plaintiffs' allegations that they had been prevented from petitioning their government had properly been dismissed by the trial court. Thereafter, the Court focused on the plaintiffs' contention that the Medical Group possessed a virtual monopoly over the provision of medical care in Ridgecrest and the surrounding area and that, as a result, it was under a common law duty to serve all persons seeking medical care without discrimination.

Initially, the Court recognized that such a common law duty in fact did exist, citing an earlier California Supreme Court case in which a labor union holding a monopoly over the labor supply in a geographic area was precluded from discriminating against black laborers who could not obtain union membership because of their race.[5] From this, the Court determined that "a medical corporation which provides the only medical services in a given geographical area appears to be precluded from discrimination in providing [those] services."

However, the Court went on to analyze the plaintiffs' complaint and determined that it was deficient because of a lack of factual allegations supporting the plaintiffs' "naked contention" that the Medical Group enjoyed a monopoly. Thus, the Court determined that the plaintiffs should be given an opportunity to amend their complaint to set out certain facts, such as: "The number of other hospitals or emergency rooms available to the residents of Ridgecrest, their distance from Ridgecrest, available individual doctors in Ridgecrest, their number and whether they provide emergency care." Assuming those facts were available, the plaintiffs could then show that the Medical Group enjoyed a monopoly over the provision of emergency services and had unlawfully discriminated against the plaintiffs in failing to provide emergency care.

Applying the *Leach* Case in Georgia

A narrow reading of the *Leach* decision would eliminate most if not all concerns which that decision poses for Georgia physicians, for a number of reasons: The decision reached by the Court in the *Leach* case is based upon California law, was rendered by a court sitting in California, and need not be followed by a court sitting in Georgia.[6] In addition, since the physician-patient relationship between the Medical Group and the plaintiffs in fact had been created, the case might have been decided on the more narrow theory of unlawful "abandonment" — that the Medical Group may have breached its duty of care to the plaintiffs (i.e., abandoned them) by improperly refusing to continue to provide them with medical care in an emergency situation. In fact, this theory presently exists in Georgia law; as described by one court: "Before a physician can abandon or withdraw from a case without liability therefor, he must either give reasonable notice, or provide a competent physician in his place. A physician who leaves a patient at a critical stage of the disease, without reason, or sufficient notice to enable the party to procure another medical attendant, is guilty of a culpable dereliction of duty."[7]

Similarly, the *Leach* case may be easily distinguishable on its facts, such that its reasoning would be inapplicable in cases where the refusal to treat was based upon some *legitimate* justification rather than on the basis of the patients' complaints to the State regulatory authorities. And, most importantly, even assuming that the

same facts were presented to a Georgia court, it is not clear *under Georgia law* that a medical group with monopoly power has any greater duty to provide treatment than that required of any other medical group or physician.

When viewed more broadly, however, the *Leach* case provides an interesting topic for debate: Although there is no law in Georgia that requires a physician to undertake the treatment of every patient who applies to the physician, should the physician's duty be dependent upon the existence of other physicians in the area? According to the *Leach* case, it may be; at a minimum, it appears that a patient may not be thrown out of court without being given an opportunity to make and prove that allegation.

Notes

1. *Buttersworth v. Swint,* 53 Ga. App. 602, (1936).
2. See, "Current Opinions of the Judicial Council of the American Medical Association," Para. 8.10 (1982).
3. *Williams v. Hospital Authority of Hall County,* 119 Ga. App. 626 (1969). The question of whether *private* hospitals are under a similar duty has not been decided as of yet in Georgia.
4. 192 Cal. Rptr. 650 (Cal.App. 5 Dist. 1983).
5. *James v. Marinship Corp.,* 25 Cal.2d 721 (1944).
6. It is debatable, at least as to the California Court's reasoning on the injunction issue, whether a Georgia court would choose to follow the *Leach* decision. While the Court technically is correct in its assertion that the injunciton would be enforced against a corporate entity (the Medical Group), rather than against an individual physician, this distinction may be one of form but not substance. In fact, the result of the injunction would be that an individual physician (a member of the Medical Group) would be required, perhaps against his will, to treat the patient.
7. *Norton v. Hamilton,* 92 Ga. App. 727, 731 (1955).

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Does Treatment of Ventricular Premature Beats Prevent Sudden Cardiac Death?

RICHARD R. WHITLOCK, JR., M.D., *Augusta**

MANY STUDIES of the use of antiarrhythmic agents in treating patients with ventricular premature beats (VPBs) have been undertaken. Some have been dismissed as inconclusive, and many physicians have concluded that there are as yet no controlled data to indicate that antiarrhythmic drugs are successful in the prevention of sudden death. However, others take a more positive view. This paper will review some of the data which are pertinent to evaluation of the efficacy of antiarrhythmic drugs in preventing sudden death.

Review of Previous Studies

An early placebo-controlled Australian trial assessed the efficacy of phenytoin in 568 patients who survived acute myocardial infarction. VPBs were suppressed more often in treated patients than in controls in a follow-up study, but there was no significant difference in the number of deaths among the placebo and phenytoin-treated patients.[1] In another trial of procainamide in post-MI patients,[2] there was a trend toward reduction of sudden death, but the difference was not statistically significant. The doses of procainamide used in this study were relatively low. A European trial of aprindine[3] did not provide evidence of a reduction of either total cardiac or sudden death despite the fact that VPBs were suppressed in 69% of the treated patients. Even though there was no overall reduction in incidence of sudden death in the treated group, none of the sudden deaths occurred among patients in whom VPBs were totally suppressed. A British study using mexiletine also demonstrated reduction of VPB frequency but no decrease in mortality.[4] These studies have been criticized on the grounds that each trial involved only a single drug, true high-risk populations were not selected, and therapeutic plasma levels of the drugs were not consistently achieved.[5]

More recent investigations have assessed the efficacy of antiarrhythmic drugs in high-risk patients, and some have employed for each patient drugs shown to be effective in suppressing potentially lethal arrhythmias. DeSilva[6] has presented evidence that suppression of VPBs does reduce mortality. Among 141 patients with Lown Grade IV or V VPBs (VPB couplets, ventricular tachycardia or R on T VPBs), a 40% annual mortality was observed among patients in whom VPBs were not eliminated, but only 3.4% annual mortality among patients in whom VPBs were eliminated.

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Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Laurence O. Watkins, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30909.

Graboys and Lown[7] have reported results of 114 patients with malignant ventricular arrhythmias (primary ventricular fibrillation or symptomatic ventricular tachycardia). Eighty-eight of the 114 were controlled to the extent of having no VPB grades IV and V during exercise testing and 24-hour ambulatory monitoring. Twenty-six patients continued to exhibit these advanced VPB grades. Among the group deemed to have been controlled, there were four sudden cardiac deaths during an average follow up of 21½ months. However, among the 26 patients with persistent advanced VPB grades, there were 13 sudden deaths during an average follow up of 15½ months.

In 1977, these authors[8] published their observations on 43 consecutive patients with ventricular fibrillation or ventricular tachycardia with syncope. For twenty-six patients the investigators attempted systematically by means of acute drug testing to select two independently effective drugs. Twenty-four of the 26 patients demonstrated control of arrhythmias, and all were alive at a mean follow up of 17 months. Seventeen patients in a second group received standard antiarrhythmic therapy based on clinical factors and "therapeutic" blood levels. Ten of these 17 patients in the second group died during a mean follow up of 14.8 months.

In 1982, these authors[9] reported their experience with 123 patients with ventricular fibrillation and ventricular tachycardia causing hemodynamic compromise. Over a mean follow up of 29.6 months, only six sudden deaths occurred among 98 patients in whom antiarrhythmic drugs abolished grades IV B (ventricular tachycardia) and V VPBs beats (2.3% annual mortality). Seventeen of the 25 patients (68%) in whom advanced grades of VPBs were not controlled died suddenly. Among 44 patients with left ventricular dysfunction, control of VPBs was an important factor in predicting survival. The annual sudden death rate for the 12 noncontrolled patients with left ventricular dysfunction was 41%. In contrast, the annual mortality rate among the 32 patients with control of advanced grades of VPBs and similar abnormalities in ventricular function was only 3.1%.

More recent studies suggest that in high-risk groups of patients, suppression of ventricular premature beats, especially advanced grades, is effective in reducing the risk of sudden death.

Many investigators have used electrophysiologic studies to guide selection of antiarrhythmic drugs, especially for patients who have experienced cardiac arrest or symptomatic ventricular tachycardia. Mason and Winkle[10] found that recurrence of ventricular tachycardia in a series of 14 patients was prevented during an average follow up of 8.1 months by drugs selected by means of electrophysiologic techniques.

Ruskin and associates[11] treated 31 survivors of prehospital cardiac arrest. VT was inducible during electrophysiologic study in 25 patients. This response was prevented by antiarrhythmic drugs in 19 patients, and no recurrence of cardiac arrest or death was observed in a 15-month follow up.

Horowitz[12] reviewed results involving a total of 232 patients from multiple studies that employed electrophysiologic testing. Prevention of inducible VT was a therapeutic end-point. Only nine (7%) sudden deaths occurred among 128 patients free of inducible VT over an average follow up of 12 to 18 months. There were 17 such deaths among 134 patients (12.6%) with persistently inducible VT. Ruberman and coworkers[13] suggest that failure to induce sustained ventricular arrhythmias in a patient after antiarrhythmic drug therapy predicts a rate of recurrence of only 5% over 2 years. If such an arrhythmia is inducible, despite therapy, this predicts a 90% recurrence rate within 1 year.

It should be noted that approximately 25% of cardiac arrest survivors will not have VT induced at their initial study. Many such patients have severe coronary disease and normal left ventricular function, and it is likely that cardiac ischemia resulting from exertion was the factor precipitating the episode of ventricular

fibrillation.[14] Tommaso and coworkers[15] have treated a subgroup of patients with severe coronary disease and normal left ventricular function with drugs intended to reduce the likelihood of ischemia. No membrane stabilizing antiarrhythmic agents were used in their series. No patient had a recurrence of ventricular fibrillation.

These more recent studies suggest that in high-risk groups of patients, suppression of VPBs, especially advanced grades, is effective in reducing the risk of sudden death. Techniques such as acute drug testing with continuous electrocardiographic monitoring and electrophysiologic stimulation allow the selection of the most effective drugs for individual patients. Factors such as the presence of ventricular dysfunction and the prevention of myocardial ischemia should influence the choice of therapy.

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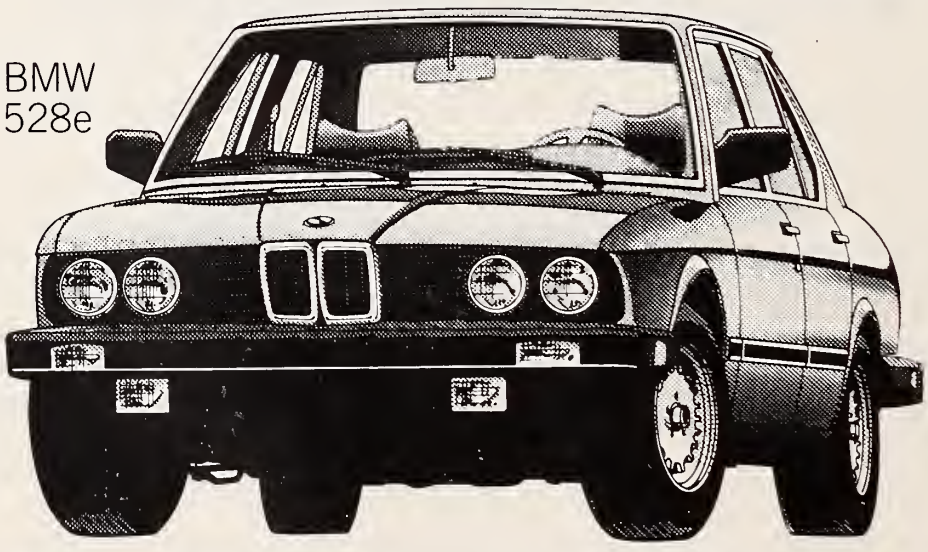
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Genitourinary Tumors IV: Adenocarcinoma of the Kidney

SAM D. GRAHAM, JR., M.D., *Atlanta**

Adenocarcinoma of the kidney (renal cell carcinoma, clear cell carcinoma, Grawitz tumor, etc.) is the most common carcinoma of the adult kidney. The estimated incidence of this cancer is less than 3% of all adult malignancies, yet due to its biologic behavior and metastatic potential, the incidence of mortality is somewhat higher. The age of peak incidence, as in most genitourinary malignancies, is 50-60, and there is a 3:1 male preponderance.

Microscopically, renal cell carcinoma may exhibit clear, granular, or sarcomatoid forms either as a pure cell type or a mixture. The clear cell form reflects an abnormal accumulation of cholesterol which is removed in the staining process. Grossly, the tumors are of the renal cortex and appear to be derived from proximal tubule cells. The smaller tumors tend to have a fibrous pseudocapsule consisting of compressed renal parenchyma surrounding them, but this is not always readily identifiable in the larger tumors.

Staging

The staging of renal carcinomas reflects the prognosis and thus dictates the therapy used. Stage I tumors are confined to the kidney, not invading the renal capsule. Stage II tumors show invasion through the renal capsule, into the perinephric fat, but confined to Gerota's fascia. Stage III lesions are subclassified into III-A, involving the renal vein or vena cava; III-B, involving the para-aortic or paracaval lymph nodes; and III-C, involving both A and B. Stage IV reflects distant metastatic disease. Survival statistics in renal cell carcinoma show an interesting anomaly in the staging system (Table I). Stage I patients can expect a 65% 5-year and 56% 10-year survival. Stage II patients show a 47% 5-year and 20% 10-year survival, yet stage III-A patients show a 66% 5-year, 49% 10-year survival if only the renal vein is involved, and a 55% 5-year, 43% 10-year survival if the tumor thrombus extends into the vena cava. Clearly, a tumor thrombus into the venous system carries a better prognosis than extension into the perinephric fat. Stage D disease carries an abysmal 0% 5-year survival.

Attempts to distinguish benign from malignant renal neoplasms based on the usual pathologic criteria are difficult. Mitoses may be infrequent, and pleomorphism is likewise uncommon. The older literature has suggested that cortical lesions less than 2 cm. in size be designated as adenomas, but even the original data supporting this view show that lesions <2 cm have a low but significant rate of metastases, supporting the present contention that all lesions should be considered carcinomas.[1, 2]

* Dr. Graham is Assistant Professor, Section of Urology, Emory University School of Medicine, Atlanta, GA 30322. Send reprint requests to him.

This paper is the last in a 4-part series on genitourinary tumors and was prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to Gray T. Fountain, M.D., 910 N. Jefferson, Albany, GA 31708.

TABLE I — Survival From Renal Cell Carcinoma

Stage	Site	% Survival 5 Year	% Survival 10 Year
I	Confined to Capsule	65	56
II	Into Perinephric Fat	47	20
III a	Renal Vein	66	49
	Vena Cava	55	43
b	Para-Aortic Nodes	20	
c	A + B		
IV	Distant Metastases	0	0

Metastases of renal cell carcinoma are to the lungs (55%), nodes (34%), liver (33%), bone (32%), adrenal (19%), contralateral kidney (11%), and other sites including brain, heart, spleen, bowel, and skin. Over half of all patients with renal carcinoma will present with metastatic disease.

Etiology

The etiology of renal cell carcinoma is unclear. Experimental evidence suggests that ionizing radiation may be a potential cause. In Syrian hamsters, diethylstilbestrol will induce a hormonally dependent renal carcinoma. In humans, exposure to tobacco products involves a slightly higher risk, and thorotrast, a radiocontrast agent, has a significantly increased risk, probably due to the ionizing radiation from the thorium. Genetics also play a part in renal cell oncogenesis, with certain inheritable diseases, notably von Hippel Lindau, carrying a very high risk of renal cell carcinoma.

Signs and Symptoms

Renal cell carcinoma causes hematuria (59%), pain (41%), and abdominal mass (45%). These three signs and symptoms, however, together known as the classic triad, were found in only 9% of all patients. Furthermore, any one or combination of these usually reflected extensive disease, since hematuria implies invasion of the collecting system, pain reflects either renal capsular distension due to changes in tumor size, invasion of surrounding nerves, or clot obstruction, and a palpable abdominal mass reflects a large tumor. Other associated abnormalities include fever (7%), weight loss (28%), anemia (21%), erythrocytosis (3%), hypercalcemia (3%), varicocele (2%), and hepatorenal dysfunction (10%). A significant number of patients will present with an asymptomatic lesion found on an IVP for some other cause, and this subset of patients will have an overall significantly improved survival (65%) over the general population of patients with renal cell carcinoma (37%).

Some of the abnormalities found in patients with renal cell carcinoma reflect an ability of the tumor to function as an endocrine-like tissue. For example, hypertension may be renin induced either by secretion from the tumor or from ischemia induced by the tumor. Erythropoetin has been demonstrated to be elevated in over 50% of patients with renal cell carcinoma, yet erythrocytosis is evident in very few patients. Parathormone release has likewise been demonstrated, yet usually the hypercalcemia is due to bony metastases. A reversible hepatopathy not associated with metastatic disease has been described by Stauffer in which liver enzymes are elevated but return to normal following nephrectomy.[3]

Diagnosis

Renal cell carcinoma is usually diagnosed radiologically. A tumor may be first demonstrated as an asymptomatic mass lesion on IVP. Currently, at Emory University, we are using bolus nephrotomography as our initial diagnostic study. Experience has shown that this study carries an accuracy rate in excess of 90% in delineating mass lesions. CT scanning is our second step to determine both the type of mass lesion (cystic vs. solid) and extent of disease (size, invasion outside the kidney, venous thrombus, nodes, liver, or bony metastases). Using these two

studies alone, we can expect an overall accuracy rate of 98 + % in preoperative diagnosis. Preoperative staging includes a bone scan and chest x-ray. We are retreating from using transfemoral aortic and selective renal arteriography as a routine study. Digital venous imaging will give adequate information in regards to vasculature and carries far less morbidity. Lymphangiography and ultrasound have been essentially replaced by CT scanning.

Treatment

The treatment of renal carcinomas is primarily surgical. Any patient with Stage I, II, or III disease is considered a surgical candidate, since chemotherapy and radiation therapy have very little impact on this disease. The operation consists of a flank incision and total removal of the kidney, including the surrounding perinephric fat, Gerota's fascia, lymph nodes, and adrenal gland. A small group of Stage IV patients, with a documented solitary metastasis, are also surgical candidates, providing the metastasis is amenable to surgical extirpation. Patients with lesions in solitary kidneys or bilateral lesions are either treated by partial nephrectomy, or as demonstrated by Graham and Glenn,[4] by enucleation of the mass from its pseudocapsule. This latter group of patients appears to have an equivalent survival as compared to patients of similar stage who undergo formal radical nephrectomy.

Recent interest has been generated in the immunologic manipulation of renal cell carcinoma. This is based on the observation that renal cell carcinoma, like melanoma, may not exhibit metastatic disease for over 10 years after primary tumor excision, suggesting that there is some host immunologic mechanism responsible. Secondly, a small group (<0.8%) of patients who have had radical nephrectomies will have spontaneous regression of their metastases. These observations coupled with the fact that renal cell carcinoma does not respond to conventional chemotherapeutic agents or radiation therapy, has prompted some investigators to try immunotherapy.

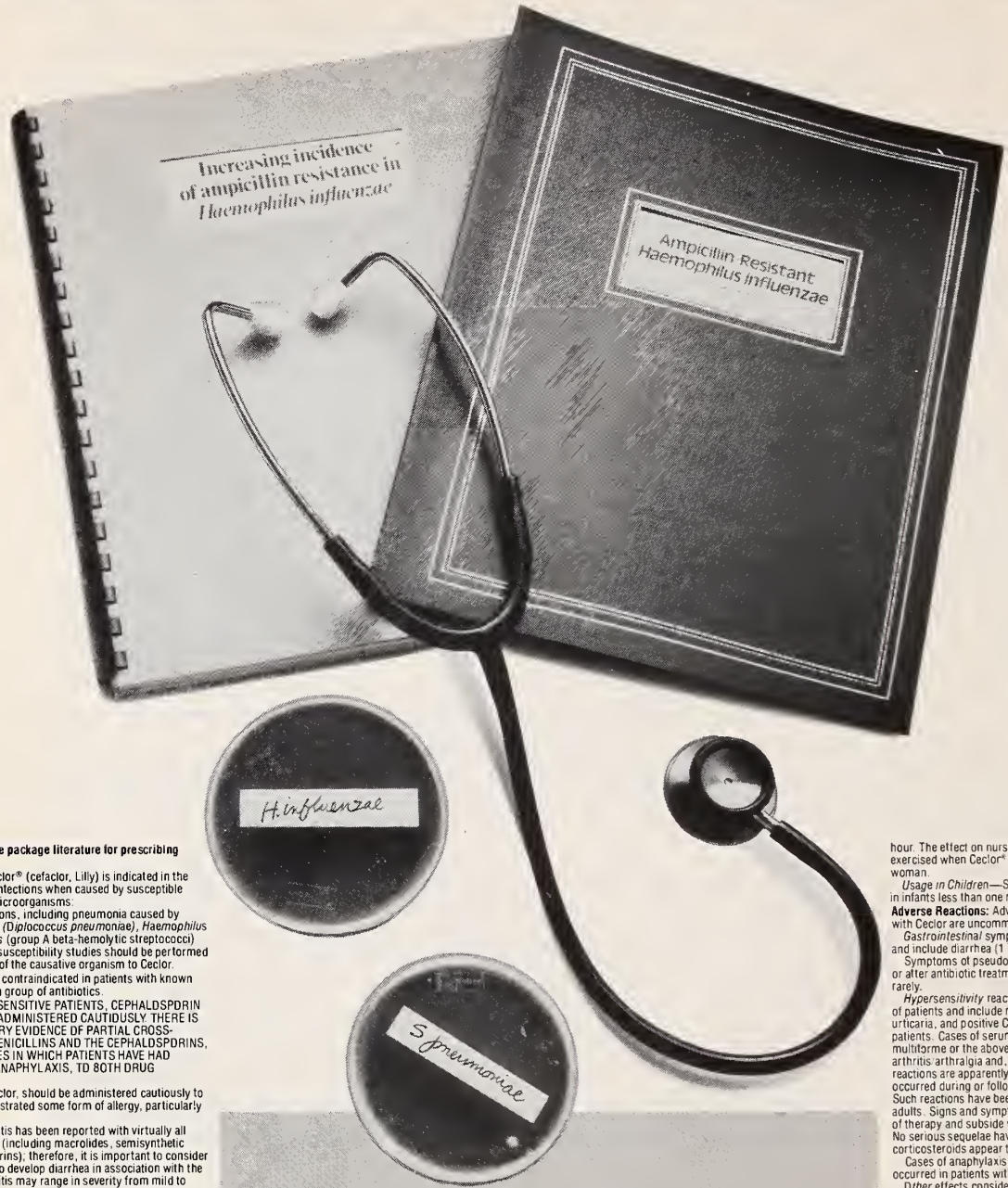
Passive immunotherapy with BCG has not been too successful, and interferon has shown mixed results. Active immunotherapy, with agents such as immune RNA or tumor vaccines has shown some promise. The largest and best controlled series has been that of Tykka,[5] who demonstrated a 25% 5-year survival in patients over controls treated with a tumor vaccine derived from autologous sonicated tumors. At Emory University, we are beginning a program for renal cell carcinoma to investigate a tumor vaccine derived from a viral oncolysate derived from a panel of renal cell carcinomas presently in tissue culture. This study will parallel the work by Cassel and Murray at Emory with a viral oncolysate for malignant melanoma.[6, 7]

Experimental evidence shows that a viral oncolysate is a far better vaccine than tumor alone or a virus-plus-tumor vaccine. At present, criteria for entry include any patient with Stage III or IV renal cell carcinoma who has a resectable primary tumor. These patients will undergo nephrectomy and subsequently begin their immunotherapy after careful preoperative staging. Tykka's data suggest that adjuvant immunotherapy is the most effective and autologous tissue provides the best immunogen. Cassel and Murray's data suggest that heterologous viral oncolysate provides approximately the same response as autologous. Aside from the usual clinical preoperative studies and follow up, we will follow certain immunologic criteria including natural killer cell function, DNCB response, helper/suppressor cell ratios, and protein electrophoresis.

In summary, renal cell carcinoma is the most common renal malignancy of adults. The key to successful treatment is early diagnosis and surgical extirpation. Patients who have metastatic disease typically show poor responses to chemotherapy or radiation therapy, yet newer forms of immunotherapy may offer promise.

(References listed on page 861)

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*[8]
Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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PERSONALS

First District

Charles E. Bohler, M.D., a family practitioner from Brooklet, participated in the autumn lecture series sponsored by the American Medical Students Association at the Medical College of Georgia. Small town medicine was the focus of this series, and Dr. Bohler discussed setting up a practice in a small town.

Second District

Tifton internist, **Joseph M. Turner, M.D.,** was recently elected to Fellowship in the 57,000-member American College of Physicians.

Third District

Horatio V. Cabasares, M.D., a general surgeon and resident of Perry, was officially welcomed in September as a Fellow of the International College of Surgeons.

Fifth District

East Point obstetrician/gynecologist, **Ivan A. Backerman, M.D.,** was officially welcomed as a Fellow of the International College of Surgeons at its annual meeting in Ohio in September.

Casandra Evans, M.D., of Atlanta, was named the head of the Emergency Physician Staff at the North Fulton Medical Center which opened in November. A Fellow of the American College of Emergency Medicine, Dr. Evans comes from R. T. Jones Hospital in Canton.

David G. Stroup, M.D., and **William H. Kilpatrick, M.D.,** recently attended the 4th District American College of Obstetrics and Gynecology meeting in London.

Eighth District

Terrell S. Roberts, M.D., opened his general/family medical practice in Hazelhurst in October.

Family practitioner, **Ric Zarzuela, M.D.,** of Waycross spoke on the role of the family practitioner at the Waycross Lions Club in October.

Ninth District

Philip A. Sheffield, M.D. has opened an otolaryngology practice in Winder. He was formerly associated with the emergency room at Winder-Barrow Hospital.

Tenth District

One of the guest speakers at the autumn lecture series sponsored by the American Medical Students Association at the Medical College of Georgia (MCG) was **Patrick Morgan, M.D.,** Assistant Professor of Family Practice at MCG. Dr. Morgan spoke on the Tri-County Health Systems, a group of clinics operated by the Family Medicine Department to provide health care in three nearby counties.

Howard C. McMahan, M.D., and **Dennis R. Thomas, M.D.,** both family practitioners, have opened a new practice in Washington.

Highlights — MAG Executive Committee, October 22, 1983

Ad Hoc Committee on Operations — MAG President William W. Moore, Jr., appointed an ad hoc committee to study MAG's entire administrative operation and use of personnel. Serving on the committee will be the four most recent past presidents of the Association: Earnest C. Atkins, H. Hilt Hammett, Jr., L. Newton Turk, III, Charles D. Hollis, Jr. Dr. Moore will serve as chairman and the Association's President-Elect, S. William Clark, Jr., will serve as an observer.

Disciplinary Actions of the Composite State Board — At its September meeting, the Executive Committee (EC) considered whether to write a letter supporting the Composite State Board of Medical Examiners' policy of disseminating the results of its disciplinary actions. The Board had disciplined a physician and notified hospitals and others of its action. The physician sued the Board, and the Board requested a letter of support from MAG.

After receiving advice from legal counsel, the EC decided to support the Board by a letter affirming MAG's position that dissemination of such information in most cases serves the public interest. The letter became unnecessary, however, when the suit against the Board was dropped by the physician.

Physician Placement — The EC approved a plan to assist communities in Appalachian Georgia recruit and retain physicians. The plan was submitted by the Access to Health Care Committee. The project, funded by the Appalachian Regional Commission, will run to September 15, 1984.

The EC also approved a new charge for the Access to Health Care Committee. The new charge is "to plan and conduct programs to improve access to health care in Georgia. A principal method of providing this service is assisting in the recruitment and retention of physicians in localities where there is a need for additional physicians."

Countersuit Review — In September, EC discussed a countersuit of a member physician. At that time, EC referred the matter to legal counsel to determine how MAG might most appropriately provide moral support to the physician. Following discussion, EC upon advice of legal counsel, voted that the President write a letter of support from MAG.

In a related action, the EC voted to write a second letter indicating MAG's concern about the road blocks the physician encountered in his countersuit, stressing that MAG is attempting to amend the law so that physicians in the future can more easily countersue after being subjected to frivolous malpractice claims.

Operation Care — At the September meeting of the Board of Directors, an action was taken to abolish as of January 1, 1984, Operation Care, Inc., MAG's program to provide free medical care to the unemployed. Following discussion, EC voted to terminate its actual operation on January 1 and turn the project over to the county medical societies. EC emphasized the tremendous public relations benefits to the county medical societies and offered MAG's assistance in the form of consulting services for the operation of local programs.

Nursing — The EC approved a resolution submitted by the Joint Nursing Committee (of MAG and the Georgia Nurses Association) supporting tuition reimbursement and flexible work schedules for nurses enrolled in academic programs. A second resolution from the Joint Practice Committee, calling for the establishment of joint practice committees in heatlh care facilities, was deferred by EC.

Nuclear Magnetic Resonance Advisory Committee Proposed Standards — Presented to EC was a recent report from the Georgia Statewide Health Coordinating Council's Nuclear Magnetic Resonance Advisory Committee of proposed standards for the use of Nuclear Magnetic Resonance (NMR) imaging in Georgia. There was some concern expressed over the apparent bias exhibited in the proposed standards. For example, the standards recommend that insurance carriers not reimburse non-hospital NMR units. After discussion, EC accepted the Nuclear Magnetic Resonance Advisory Committee's report as information, with the understanding that this report was interim in nature and that another proposal would be forthcoming from the Advisory Committee in January.

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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of the medical association of georgia

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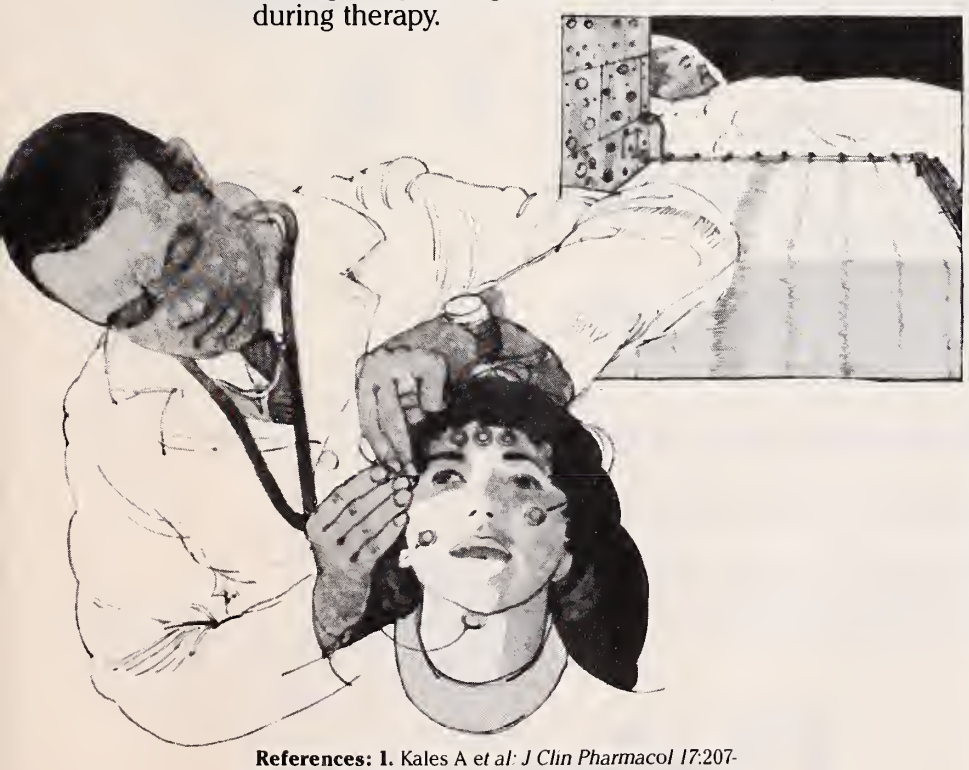
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